

#10

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

**PETITION FOR REVIVAL OF AN APPLICATION FOR PATENT ABANDONED  
UNINTENTIONALLY UNDER 37 CFR 1.137(b)**

Docket Number (Optional)

First named inventor: DENNIS M. DEARIE

Application No.: 096611361

Filed: 4-21-04

Title: OWNER

Art Unit:

Examiner:

**RECEIVED**

APR 22 2004

**OFFICE OF PETITIONS**

Attention: Office of Petitions

**Mail Stop Petition**

Commissioner for Patents

P.O. Box 1450

Alexandria, VA 22313-1450

FAX: (703) 872-9306

NOTE: If information or assistance is needed in completing this form, please contact Petitions  
Information at (703) 305-9282.

The above-identified application became abandoned for failure to file a timely and proper reply to a notice or action by the United States Patent and Trademark Office. The date of abandonment is the day after the expiration date of the period set for reply in the Office notice or action plus an extensions of time actually obtained.

**APPLICANT HEREBY PETITIONS FOR REVIVAL OF THIS APPLICATION**

NOTE: A grantable petition requires the following items:

- (1) Petition fee;
- (2) Reply and/or issue fee;
- (3) Terminal disclaimer with disclaimer fee --required for all utility and plant applications filed before June 8, 1995; and for all design applications; and
- (4) Statement that the entire delay was unintentional.

**1. Petition fee**

☒ Small entity-fee \$ 55.00 (37 CFR 1.17(m)). Applicant claims small entity status. See 37 CFR 1.27.

☐ Other than small entity - fee \$ \_\_\_\_\_ (37 CFR 1.17(m))

**2. Reply and/or fee**

A. The reply and/or fee to the above-noted Office action in

the form of \_\_\_\_\_ (identify type of reply):

- ☐ has been filed previously on \_\_\_\_\_  
☐ is enclosed herewith.

B. The issue fee of \$ \_\_\_\_\_

- ☐ has been paid previously on \_\_\_\_\_  
☐ is enclosed herewith.

[Page 1 of 2]

This collection of information is required by 37 CFR 1.137. The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.14. This collection is estimated to take 1.0 hour to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. **SEND TO: Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.**

If you need assistance in completing the form, call 1-800-PTO-9199 and select option 2.

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

### 3. Terminal disclaimer with disclaimer fee

- ☐ Since this utility/plant application was filed on or after June 8, 1995, no terminal disclaimer is required.
- ☐ A terminal disclaimer (and disclaimer fee (37 CFR 1.20(d)) of \$ \_\_\_\_\_ for a small entity or \$ \_\_\_\_\_ for other than a small entity) disclaiming the required period of time is enclosed herewith (see PTO/SB/63).

4. STATEMENT: The entire delay in filing the required reply from the due date for the required reply until the filing of a grantable petition under 37 CFR 1.137(b) was unintentional. [NOTE: The United States Patent and Trademark Office may require additional information if there is a question as to whether either the abandonment or the delay in filing a petition under 37 CFR 1.137(b) was unintentional (MPEP 711.03(c), subsections (III)(C) and (D))].

**WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.**

4-20-04

Date

Dennis M. Dearie

Signature

Telephone  
Number:

(252)-262-0561

DEXNIS M. DEARIE

Typed or printed name

15431 RED MAPLE PLACE

Address

GREENWELL SPRINGS, LA. 70895

Address

Enclosures: ☒ Fee Payment

☒ Reply

☒ Terminal Disclaimer Form

☒ Additional sheets containing statements establishing unintentional delay

☐ Other: \_\_\_\_\_

### CERTIFICATE OF MAILING OR TRANSMISSION [37 CFR 1.8(a)]

I hereby certify that this correspondence is being:

☒ deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to: **Mail Stop Petition**, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

☐ transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (703) 872-9306.

4-21-04

Date

Dennis M. Dearie

Signature

DENNIS M. DEARIE

Type or printed name of person signing certificate

Mr. Douglas I. Wood  
Senior Petitions Attorney  
Office of Petitions

RECEIVED

APR 22 2004

OFFICE OF PETITIONS

Mr. Wood,

I'd like to inform you of my past medical problems that may help you understand what was going on at my house and in my life when we initially applied for a patent on our "I.V.S." (Insurance Verification System). I hurt my back on a job in Omaha in Oct. 1994. I was told by my doctor to get a desk job which I did. The back continued getting worse and in July of 2000 I was forced to quit the job. In Oct. of 2000 I woke up and had no feeling from the waist down. I was rushed to the hospital and they found my spine had an infection in it. It caused blood infection and I was "touch-n-go" for a while. After 15 days in the hospital I was released and was fitted with a shoulder bag and being fed antibiotics 24/7. After 6 months I had my first surgery. They took out 35% of L-4 and L-5, took out the disc between them, as it was also dead bone. Then he took a piece of bone from my hip and wedged it in my spine. I couldn't get out of bed for 30 days. A year or so later (Jan. 2002) I had my second back surgery. More dead bone and infection. It seemed we saw light at the end of the tunnel then bang I had to have triple by-pass in Jan. 2004. And in between all this mass confusion somehow my application was lost in the patent office. The only thing I can see is my wife should've gotten a receipt when she mailed the Jan. response. And I should've told her to make copies of what she was sending but things were going crazy not knowing if I was going to be alive or not!!!!

Thank You For Your Time And Patience,

Dennis M. Dearie  
(225) 262-0561

*P.S. Any mistakes - PLEASE - call me ASAP - so I can  
fix them.  
Thanks  
Dennis*

Dennis M. Dearie  
15431 Red Maple Place  
Greenwell Springs, LA. 70739  
(225) 262-0561

April 20, 2004

Mr. Douglas I. Wood; Senior Petitions Attorney,

I am the sole inventor and designer of the wireless system using a barcode on an automobile's inspection sticker or windshield or glass to check for the status of insurance policies on said vehicle. The system is called "Insurance Verification System" or "IVS". My system uses a wireless barcode reader that is tied directly to our internet server. (This can also be written to use state's data terminal) We have written spec's to use our server that way in future uses other states can be tied in seamlessly.

Basics of the system are as follows: To get vehicles on system for the first time, the following guidelines/steps are (1) Application for policy is made, issuing company "logs on" to DesignScan's server, each company and employee will have their own secured "log on" number and password, 2) after "logging on" the following fields are entered Policy number, Effective and Expiration Dates, Name, Address, and Phone Number of the policy holder, Vehicle Identification Number (VIN), Year, Make, Model, and Color of the covered vehicle. Those steps take only two minutes or less to do. That information is then submitted into server and cannot be altered or changed except by the issuing company. Company then prints out temporary card to be used until inspection sticker is renewed.

When it becomes time to renew inspection sticker the station completes the process. The state shall print out new stickers with a

barcode on the bottom portion of the sticker. The station also "logs on" to the DesignScan server. Once there they will enter the VIN which will take them to the "inspection page". The inspection page displays VIN, year, make, model, and color of vehicle. They then will be able to cross reference that the correct vehicle and VIN are the same. After highlighting the barcode section the inspector will use a barcode reading pen and swipe the next sticker. Upon completion that the barcode field is correct he'll then enter the appropriate date, mileage, and license plate number. After successfully passing the inspection and filling out all fields the inspector submits information into computer. Now the vehicle is on the IVS System.

When it comes time to renew inspection sticker the owner doesn't need insurance papers. The station "logs on" to the DesignScan server, inputs the VIN and he'll be able to check if a policy is in effect for that vehicle. When a vehicle is "scanned" the reader sounds one way if there are no problems and another if that vehicle doesn't have a valid policy at the time of the scan. This saves time at check points and protects drivers who've lost or misplaced papers. It also helps law enforcement individuals from someone rummaging through the glove box late at night and pulling out a gun or something else. Plus there will be no more excuses, either you have insurance or you don't.

Thank You,  
Dennis R. Pearson

UNICARE UTILIZATION MANAGEMENT  
2727 PACES FERRY ROAD, BLDG. 2  
STE. 600  
ATLANTA, GA 30339



UNICARE®

DENNIS DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS LA 70739

Reference No: 0200584271  
Provider: ROBERT THURSTON  
Facility/Vendor: BATON ROUGE GENERAL  
HEALTH CENTER  
Client: UL&H LARGE GROUP 2  
Patient: DENNIS DEARIE  
Subscriber: MICHELLE DEARIE  
Admit Date: N/A  
Date Created: 23-Jan-2004 18:25

Service	Date	Quantity	Code	Description
Surgical	21-Jan-2004	1 Unit(s)	33518	CABG, artery-vein, two

Review Outcome: Certification  
Place of service: Hospital - Additional IP Procedure

**The requested services have been certified as listed above based on medical necessity.** The healthcare provider listed above is a network provider. The healthcare facility/vendor listed above is not a network facility/vendor. Using a non-network facility/vendor may result in reduced benefits and/or higher out-of-pocket expenses. For information regarding network facilities/vendors, please contact us at the toll-free number listed below. This determination is valid for 90 days from the Service Date listed above. If the Services Date changes, please contact us at the toll-free telephone number listed below. This determination is a recommendation regarding the medical necessity of the services listed above. The decision regarding what treatment is best remains with the patient and the healthcare provider.

This letter and the associated review, do not guarantee claims payment. No benefit determination has been made at this time. Payment of benefits could be limited or denied if the information submitted with claims differs from that given by telephone, and is subject to all policy exclusions, limitations, waivers, pre-existing conditions and coverage eligibility when the services listed above are provided.

For questions regarding this letter please contact:

Name: UNICARE UTILIZATION MANAGEMENT  
Toll-Free Telephone: (800) 762-4534 X2106  
Facsimile: (770) 805-6218  
Address: 2727 PACES FERRY ROAD, BLDG. 2  
STE. 600  
ATLANTA, GA 30339

Sincerely,  
Care Manager

**BATON ROUGE RADIOLOGY GROUP, INC**

8490 PICARDY AVE, #500A  
 BATON ROUGE, LA 70809  
 (225) 769-6700

Check Card Using For Payment

MASTERCARD		VISA	
Card Number		Amount	
Signature		Exp. Date	
ACCOUNT NO	STMT DATE	AMOUNT DUE	AMOUNT PAID
442263	03/01/2004	\$138.00	

**ADDRESSEE**

DENNIS DEARIE  
 15431 REDMAPLE PLACE  
 GREENWELL SPRIN, LA 70739

**REMIT TO**

BATON ROUGE RADIOLOGY GROUP, INC  
 PO BOX 14530  
 BATON ROUGE, LA 70898

030109060000442263000002154500000138007

Detach and return top portion to ensure proper credit - Retain bottom portion for major medical and tax purposes

**ACCOUNT DETAIL (Patient resp. is calculated as of statement date)**

Account#: 442263

Date	Description	Charge	Responsibility		Balance
			Insurance	Patient	
01/19/2004	01: DEARIE, DENNIS 71020: CHEST 2 VIEWS; AP/PA + LATERAL (DE LA BRETONNE, M.D.) at BRGMC - BLUEBONNET	37.00		37.00	37.00
02/03/2004	\$37.00 claim Filed with primary insurance UNICARE LIFE + HEALTH INSURANCE				
02/21/2004	71010: CHEST SINGLE VIEW; AP/PA (ALLEVA, M.D.) at BRGMC - BLUEBONNET	32.00		32.00	69.00
02/05/2004	\$32.00 claim Filed with primary insurance UNICARE LIFE + HEALTH INSURANCE				
01/21/2004	71010: CHEST SINGLE VIEW; AP/PA (TSAI, M.D.) at BRGMC - BLUEBONNET	32.00		32.00	101.00
02/05/2004	\$32.00 claim Filed with primary insurance UNICARE LIFE + HEALTH INSURANCE				
01/24/2004	71020: CHEST 2 VIEWS; AP/PA + LATERAL (ALEXANDER, M.D.) at BRGMC - BLUEBONNET	37.00		37.00	138.00
02/09/2004	\$37.00 claim Filed with primary insurance UNICARE LIFE + HEALTH INSURANCE				
<b>NOTES</b> NOTICE: THIS IS A BILL. BASED UPON INFORMATION FROM YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN.  <i>3/30 -          don't see claim filed          on website</i>					
Current	30-60	60-90	90-120	Over 120 Days	
\$138.00	\$0.00	\$0.00	\$0.00	\$0.00	
			\$0.00	\$138.00	\$138.00
<b>Please Pay This Amount: \$138.00</b>					

Regardless of insurance coverage you are responsible for payment of this account. If you have any question regarding this statement, please call the main office.

BRRG: BATON ROUGE RADIOLOGY GROUP, INC

Type of Bill	Date of Bill	Date of Prev. Bill
FINAL INP.	01/28/04	

P.O. BOX 54376  
NEW ORLEANS, LA  
225 819-1000  
FEI # 721025017

70154

S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

Guarantor Name and Address	COB	Insurance Company Name	Group No.	Policy Number
DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
THURSTON R SCOTT				

To Insure Proper Credit, Return Top Portion With Your Remittance								
Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
01/21	21SPRE OP SDS TIM	3201080						
01/21	016MAJOR IV SURGE	3210435	9544.00	9544.00				
01/21	001CATH SWAN GANZ	3260075	975.00	975.00				
01/21	001PLEURAVAC CHES	3260085	439.00	439.00				
01/21	002SUTURE O-FLEXO	3260099	180.00	180.00				
01/21	001CATH PERC INTR	3260128	208.25	208.25				
01/21	001CATH CRITICORE	3260162	235.25	235.25				
01/21	001TEGADERM 2 X 3	3260206	3.75	3.75				
01/21	001KIT ARTERIAL M	3260553	182.00	182.00				
01/21	001TEGADERM 4 X 5	3260575	11.75	11.75				
01/21	001TUBE SALEM SUM	3260592	14.00	14.00				
01/21	001CATH RUBBER NE	3260678	49.50	49.50				
01/21	001CATH RUBBER NE	3260678	49.50	49.50				
01/21	001BLANKET HYPOTH	3260684	182.50	182.50				
01/21	001ADAPTIC ALL SI	3260718	11.75	11.75				
01/21	001VALVE KEITH AN	3260725	32.00	32.00				
01/21	001BAG DECANter	3210026	18.25	18.25				
01/21	001ADAPTOR PERFUS	3210076	102.00	102.00				
01/21	001SUTURE CATEGOR	3210101	27.50	27.50				
01/21	001SUTURE CATEGOR	3210101	27.50	27.50				
01/21	001SUTURE CATEGOR	3210102	42.50	42.50				
01/21	002SUTURE CATEGOR	3210102	85.00	85.00				
01/21	001SUTURE CATEGOR	3210103	73.25	73.25				
01/21	003SUTURE CATEGOR	3210105	348.75	348.75				
01/21	001SUTURE CATEGOR	3210106	170.25	170.25				
01/21	003ENDO LIGACLIP	3210131	1124.25	1124.25				
01/21	001ENDO LIGACLIP	3210131	374.75	374.75				
01/21	001TRAY BACK TABL	3210151	950.75	950.75				
01/21	001TRAY CHEST TAB	3210152	747.50	747.50				
01/21	003LIGACLIP LC-10	3210297	82.50	82.50				
01/21	008CLIP STERNAL	3210334	148.00	148.00				
01/21	001CONNECTOR, BLA	3210336	30.50	30.50				
01/21	002DRAIN BLAKE/SY	3210395	290.00	290.00				
<div> <div>Patient Number</div> <div>Please refer to patient number in all inquiries and correspondence.</div> </div> <div> <div>Additional patient billing may be necessary for any charges not posted when this bill was prepared.</div> </div> <div> <div>Conditional endorsements or statements such as "Payment in Full" on check remittance will not be recognized as an "agreement-in-compromise" unless agreed to in writing by the Health Center.</div> </div>								

NOTICE:  
THIS IS NOT A BILL. DO NOT PAY.  
IF IT IS DETERMINED THAT THIS  
SERVICE OR A PORTION OF THESE  
SERVICES IS NOT PAYABLE BY  
YOUR HEALTH PLAN, YOU WILL  
BE RESPONSIBLE.



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S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE ,DENNIS	43365725	M	48	01/21/04	01/25/04	4

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THURSTON R SCOTT				

To Insure Proper Credit, Return Top Portion With Your Remittance								
Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
01/21	003KIT DURA PREP	3210798	140.25	140.25				
01/21	003LIGACLIP LC-20	3211040	76.50	76.50				
01/21	001SHUNT VASCULAR	3211078	325.00	325.00				
01/21	001DONUT	3211080	8.50	8.50				
01/21	001BREATHING CIRC	3211708	58.50	58.50				
01/21	001SUTURE E-PACK	3211796	277.50	277.50				
01/21	001SUTURE E-PACK	3211797	352.75	352.75				
01/21	001BAG, PRESSURE	3215000	106.50	106.50				
01/21	001BAG ADULT RESU	3217118	100.50	100.50				
01/21	001PUNCH VASCULAR	3218760	277.50	277.50				
01/21	001OCTOPUS BLOWER	3219176	383.25	383.25				
01/21	001SURGICEL FIBRI	3219194	429.00	429.00				
01/21	001STABILIZER, HE	3219252	2472.00	2472.00				
01/21	016ANESTHESIA GEN	3210436	1452.00	1452.00				
01/21	001SOLN WATER 150	3261001	39.00	39.00				
01/21	001IV SOLN D5%W 5	3400096	20.95	20.95				
01/21	001D5- 1/4 NS	3400106	28.40	28.40				
01/21	001D5- 1/4 NS	3400106	28.40	28.40				
01/21	001D 5% 1/4 N S 1	3400106	28.40	28.40				
01/21	001IV SOLN RINGER	3400187	49.05	49.05				
01/21	003IV SOLN RINGER	3400187	147.15	147.15				
01/21	002NS	3400232	41.90	41.90				
01/21	001IV SOLN NACL .	3400233	32.65	32.65				
01/21	001IV SOLN NACL .	3400234	15.55	15.55				
01/21	003SOLN NACL .9%	3400235	106.20	106.20				
01/21	001SOLN NACL .9%	3400235	35.40	35.40				
01/21	001NORMAL SALINE-	3400237	3.50	3.50				
01/21	001NORMAL SALINE-	3400237	3.50	3.50				
01/21	001HEPARIN 1000U	3400260	10.55	10.55				
01/21	0031/2 NS	3400282	62.85	62.85				
01/21	001IV SOLN NACL .	3400402	15.10	15.10				
01/21	001POTASSIUM CHLO	3400708	63.55	63.55				
01/21	001BASIC METABOLI	4050277	164.75	164.75				
01/21	001GLUCOSE; SERUM	4050644	38.00	38.00				
Patient Number		Please refer to patient number in all inquiries and correspondence.		Additional patient billing may be necessary for any charges not posted when this bill was prepared.		Conditional endorsements or statements such as "Payment in Full" on check remittance will not be recognized as an "agreement-in-compromise" unless agreed to in writing by the Health Center.		

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01/21	001POTASSIUM	4050658	37.00	37.00				
01/21	001POTASSIUM	4050658	37.00	37.00				
01/21	001SODIUM; BLOOD	4050662	38.00	38.00				
01/21	001CK; TOTAL	4050749	68.00	68.00				
01/21	001MAGNESIUM	4050753	42.00	42.00				
01/21	001HEMOGLOBIN	4080465	30.50	30.50				
01/21	001HEMOGLOBIN	4080465	30.50	30.50				
01/21	001CBC WITH DIFFE	4080593	68.00	68.00				
01/21	001HEMATOCRIT (HC	4080598	30.50	30.50				
01/21	001HEMATOCRIT (HC	4080598	30.50	30.50				
01/21	001PTT (PARTIAL T	4080653	61.50	61.50				
01/21	001PTT (PARTIAL T	4080653	61.50	61.50				
01/21	001PT ( PROTHROMB	4080659	52.00	52.00				
01/21	001PLATELET COUNT	4081013	28.65	28.65				
01/21	001X CHEST PORTAB	5010006	151.25	151.25				
01/21	001CELLSAVER INIT	2740017	327.25	327.25				
01/21	001CELL SAVER PAC	2740087	729.25	729.25				
01/21	001KIT PRESSURE M	2740088	185.50	185.50				
01/21	001ANTICOAGULANT	2740089	88.75	88.75				
01/21	001A C T	2740094	229.00	229.00				
01/21	001GABAPENTIN	3301005	5.00	5.00				
01/21	001DOCUSATE CALCI	3301380	.50	.50				
01/21	001ASPIRIN	3301526	.50	.50				
01/21	002ACETAMINOPHEN	3301755	1.00	1.00				
01/21	002EC ASPIRIN	3302649	1.00	1.00				
01/21	006VENLAFAXINE HC	3307535	52.50	52.50				
01/21	002BISACODYL	3369034	1.00	1.00				
01/21	002OXYGEN THERAPY	3500007	311.50	311.50				
01/21	001NASAL O2 CHANG	3500011	28.00	28.00				
01/21	001EXTUBATION STA	3500041						
01/21	001MECH VENT INIT	3500156	765.00	765.00				
01/21	001WEANING PARAME	3500176	10.00	10.00				
01/21	001TRACH TIES	3500234	4.75	4.75				
01/21	003PULSE OXIMETRY	3500608	406.50	406.50				
Patient Number		Please refer to patient number in all inquiries and correspondence.		Additional patient billing may be necessary for any charges not posted when this bill was prepared.		Conditional endorsements or statements such as "Payment in Full" on check remittance will not be recognized as an "agreement-in-compromise" unless agreed to in writing by the Health Center.		

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S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

Guarantor Name and Address	COB	Insurance Company Name	Group No.	Policy Number
DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
THURSTON R SCOTT				

To Insure Proper Credit, Return Top Portion With Your Remittance								
Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
01/21	001MEPERIDINE HCL	3326641	3.75	3.75				
01/21	001MEPERIDINE HCL	3326641	3.75	3.75				
01/21	001MEPERIDINE HCL	3326641	3.75	3.75				
01/21	001MEPERIDINE HCL	3326641	3.75	3.75				
01/21	002POTASSIUM CHLO	3326682	6.50	6.50				
01/21	002MAGNESIUM SULF	3326951	4.00	4.00				
01/21	002MAGNESIUM SULF	3326951	4.00	4.00				
01/21	002MAGNESIUM SULF	3326951	4.00	4.00				
01/21	001SUFENTANIL CIT	3327332	57.30	57.30				
01/21	001SUFENTANIL CIT	3327332	57.30	57.30				
01/21	003MIDAZOLAM HCL	3327366	51.60	51.60				
01/21	001THIOPENTAL SOD	3327378	11.15	11.15				
01/21	001MIDAZOLAM HCL	3327407	16.85	16.85				
01/21	002DEXMEDETOMIDIN	3327938	292.80	292.80				
01/21	003CEFAZOLIN SODI	3328027	23.25	23.25				
01/21	002CEFAZOLIN SODI	3328035	19.70	19.70				
01/21	001ROOM 2605	9100001	1370.00	1370.00				
01/22	001TEGADERM 2 X 3	3260206	3.75	3.75				
01/22	001VASELINE GAUZE	3260664	6.75	6.75				
01/22	001NS	3400232	20.95	20.95				
01/22	001NS	3400232	20.95	20.95				
01/22	001CK; MB FRACTIO	4040298	163.75	163.75				
01/22	001BASIC METABOLI	4050277	164.75	164.75				
01/22	001CK; TOTAL	4050749	68.00	68.00				
01/22	001MAGNESIUM	4050753	42.00	42.00				
01/22	001CBC WITH DIFFE	4080593	68.00	68.00				
01/22	001EXERCISE-MONIT	2650001						
01/22	001GABAPENTIN	3301005	5.00	5.00				
01/22	001GABAPENTIN	3301005	5.00	5.00				
01/22	004DOCUSATE CALCI	3301380	2.00	2.00				
01/22	001DOCUSATE CALCI	3301380	.50	.50				
01/22	003FUROSEMIDE	3301934	6.00	6.00				
01/22	002FUROSEMIDE	3301934	4.00	4.00				
01/22	001FUROSEMIDE	3301934	2.00	2.00				

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Neurontin  
Surfak  
Bumex

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Type of Bill	Date of Bill	Date of Prev. Bill
FINAL INP.	01/28/04	

P.O. BOX 54376  
NEW ORLEANS, LA  
225 819-1000  
FEI # 721025017

70154

S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

Guarantor Name and Address	COB	Insurance Company Name	Group No.	Policy Number
DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
THURSTON R SCOTT				

To Insure Proper Credit, Return Top Portion With Your Remittance								
Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
01/22	004EC ASPIRIN	3302649	2.00	2.00				
01/22	002EC ASPIRIN	3302649	1.00	1.00				
01/22	001BACLOFEN	3303411	2.10	2.10				
01/22	006POTASSIUM CHLO	3303449	12.00	12.00				
01/22	004POTASSIUM CHLO	3303449	8.00	8.00				
01/22	002POTASSIUM CHLO	3303449	4.00	4.00				
01/22	016MIRTAZAPINE	3307564	132.80	132.80				
01/22	002MIRTAZAPINE	3307566	17.10	17.10				
01/22	001OXYGEN THERAPY	3500007	155.75	155.75				
01/22	001INCENTIVE SPIR	3500212	65.50	65.50				
01/22	001PULSE OXIMETRY	3500608	135.50	135.50				
01/22	001MEPERIDINE HCL	3326641	3.75	3.75				
01/22	001MEPERIDINE HCL	3326641	3.75	3.75				
01/22	001MEPERIDINE HCL	3326641	3.75	3.75				
01/22	001MEPERIDINE HCL	3326643	3.15	3.15				
01/22	001MEPERIDINE HCL	3326643	3.15	3.15				
01/22	001MEPERIDINE HCL	3326643	3.15	3.15				
01/22	001MEPERIDINE HCL	3326643	3.15	3.15				
01/22	002MAGNESIUM SULF	3326951	4.00	4.00				
01/22	002MAGNESIUM SULF	3326951	4.00	4.00				
01/22	001PROMETHAZINE H	3327041	6.70	6.70				
01/22	001ROOM 4406	9050001	740.00	740.00				
01/23	001NS	3400232	20.95	20.95				
01/23	001NS	3400232	20.95	20.95				
01/23	001IV SOLN NACL .	3400232	20.95	20.95				
01/23	001LDH ISOENZYMES	4040744	109.00	109.00				
01/23	001BASIC METABOLI	4050277	164.75	164.75				
01/23	001MAGNESIUM	4050753	42.00	42.00				
01/23	001CBC WITH DIFFE	4080593	68.00	68.00				
01/23	001EXERCISE-MONIT	2650001						
01/23	001EXERCISE-MONIT	2650001						
01/23	001EXERCISE-MONIT	2650001						
01/23	004DOCUSATE CALCI	3301380	2.00	2.00				
01/23	003FENOFIBRATE	3307841	23.10	23.10				

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P.O. BOX 54376  
NEW ORLEANS, LA  
225 819-1000  
FEI # 721025017

70154

Page No.

6

Type of Bill	Date of Bill	Date of Prev. Bill
FINAL INP.	01/28/04	

S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

Guarantor Name and Address	COB	Insurance Company Name	Group No.	Policy Number
DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
		THURSTON R SCOTT		

To Insure Proper Credit, Return Top Portion With Your Remittance								
Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
01/23	002OXYGEN THERAPY	3500007	311.50	311.50				
01/23	001PULSE OXIMETER	3500014	22.00	22.00				
01/23	003OXYGEN EXTENSI	3507002	14.25	14.25				
01/23	001MEPERIDINE HCL	3326641	3.75	3.75				
01/23	001MEPERIDINE HCL	3326641	3.75	3.75				
01/23	001MEPERIDINE HCL	3326643	3.15	3.15				
01/23	001MEPERIDINE HCL	3326643	3.15	3.15				
01/23	001MEPERIDINE HCL	3326643	3.15	3.15				
01/23	002MAGNESIUM SULF	3326951	4.00	4.00				
01/23	002MAGNESIUM SULF	3326951	4.00	4.00				
01/23	001ROOM 4406	9050001	740.00	740.00				
01/24	001NS	3400232	20.95	20.95				
01/24	001NS	3400232	20.95	20.95				
01/24	001LIPID PANEL	4050032	97.25	97.25				
01/24	001X CHEST, 2 VIE	5010115	178.50	178.50				
01/24	001EXERCISE-MONIT	2650001						
01/24	001EXERCISE-MONIT	2650001						
01/24	001OXYGEN THERAPY	3500007	155.75	155.75				
01/24	002PULSE OXIMETER	3500014	44.00	44.00				
01/24	001MEPERIDINE HCL	3326641	3.75	3.75				
01/24	001MEPERIDINE HCL	3326643	3.15	3.15				
01/24	001MEPERIDINE HCL	3326643	3.15	3.15				
01/24	001MEPERIDINE HCL	3326643	3.15	3.15				
01/24	002MAGNESIUM SULF	3326951	4.00	4.00				
01/24	002MAGNESIUM SULF	3326951	4.00	4.00				
01/24	001ROOM 4406	9050001	740.00	740.00				
01/25	001TEGADERM 2 X 3	3260206	3.75	3.75				
01/25	001NS	3400232	20.95	20.95				
01/25	001NS	3400232	20.95	20.95				
01/25	001NS	3400232	20.95	20.95				
01/25	001NS	3400232	20.95	20.95				
01/25	001NS	3400232	20.95	20.95				
01/25	001IV SOLN NACL .	3400234	15.55	15.55				
01/25	001BASIC METABOLI	4050277	164.75	164.75				

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FINAL INP.	01/28/04	

P.O. BOX 54376  
NEW ORLEANS, LA  
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FEI # 721025017

70154

S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
DEARIE		DENNIS	43365725	M	48	01/21/04	01/25/04	4

Guarantor Name and Address	COB	Insurance Company Name	Group No.	Policy Number
DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
THURSTON R SCOTT				

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Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
01/25	001MAGNESIUM	4050753	42.00	42.00	-?			
01/25	001CBC WITH DIFFE	4080593	68.00	68.00				
01/25	001FENOFIBRATE	3307841	7.70-	7.70-				
01/25	001MEPERIDINE HCL	3326643	3.15	3.15				
01/25	001MEPERIDINE HCL	3326643	3.15	3.15				
01/25	001POTASSIUM CHLO	3326682	3.25-	3.25-				
01/25	001POTASSIUM CHLO	3326682	3.25-	3.25-				
01/25	002FUROSEMIDE 2	3326914	4.30	4.30				
01/25	002FUROSEMIDE 2	3326914	4.30-	4.30-				
01/25	002MAGNESIUM SULF	3326951	4.00-	4.00-				
01/25	002MAGNESIUM SULF	3326951	4.00-	4.00-				
01/25	002MAGNESIUM SULF	3326951	4.00-	4.00-				
<b>T O T A L S</b>			34818.85	34818.85				
Patient Number		Please refer to patient number in all inquiries and correspondence.		Additional patient billing may be necessary for any charges not posted when this bill was prepared.				
43365725								

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BATON ROUGE GENERAL MEDICAL CENTER HA9  
NEW ORLEANS, LA

HA9

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225 819-1000  
FEI # 721025017

70154

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		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

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DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739	1	AMLIFECARE/PPO *A		435114921
THURSTON R SCOTT				

Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
<b>SUMMARY OF CHARGES</b>								
	R&C INTENSI 1DAYS@	1370.00	1370.00	1370.00				
	R&C TELEMET 3DAYS@	740.00	2220.00	2220.00				
	OPERATING ROOM		9544.00	9544.00				
	SURGICAL SUPPLIES		9651.00	9651.00				
	ANESTHESIA SUPPLY		1452.00	1452.00				
	LAB		2080.65	2080.65				
	PHARMACY		902.35	902.35				
	MEDICAL SUPPLIES		2588.50	2588.50				
	IV SUPPLIES		39.00	39.00				
	IV SOLUTIONS		651.85	651.85				
	X-RAY		329.75	329.75				
	RESPIRATORY THERAP		2430.00	2430.00				
	HEART LAB		1559.75	1559.75				
	<b>SUB-TOTAL OF CHARGES</b>		<b>34818.85</b>	<b>34818.85</b>				
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<b>TOTALS</b>			<b>34818.85</b>	<b>34818.85</b>				
Patient Number	Please refer to patient number in all inquiries and correspondence.		Additional patient billing may be necessary for any charges not posted when this bill was prepared.					
43365725								

BATON ROUGE GENERAL MEDICAL CENTER HA9  
NEW ORLEANS, LA

HA9

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FEI # 721025017

70154

S	T	Patient Name	Patient Number	Sex	Age	Admission	Discharge	Days
		DEARIE, DENNIS	43365725	M	48	01/21/04	01/25/04	4

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		BILLING ABSTRACT						
	DIAGNOSIS AND PROCEDURES:							
	ADMITTING DIAGNOSIS:							
	414.01 COR AS-NATIVE VESSEL							
	DISCHARGE/FINAL DIAGNOSIS:							
	414.01 *COR AS-NATIVE VESSEL							
	401.9 HYPERTENSION NOS							
	272.4 HYPERLIPIDEMIA NEC & NOS							
	564.00 CONSTIPATION NOS							
	V17.4 FAMILY HX CV DISEASE NEC							
	SURGICAL PROCEDURES:							
	36.12 *AO-COR BYPASS-2 COR ART				01/21/04	7989		
	36.15 1 INT MAM-COR ART BYPASS				01/21/04	7989		
	89.64 PA WEDGE MONITORING				01/21/04	7559		
	38.91 ARTERIAL CATHETERIZATION				01/21/04	7989		
	99.00 PERIOP AUTLOG TRANSFUS				01/21/04	7989		
	PHYSICIAN:							
	OPERATING:							
	007989 THURSTON R SCOTT			07588R				
	ALTERNATE CARE:							
	DISCHARGE DESTINATION:							
	ATW							
T O T A L S			34818.85	34818.85				

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FINAL INP.	01/28/04		

70154

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	ADDRESSES: PATIENT: DENNIS DEARIE 15431 RED MAPLE PLACE GREENWELL SPRINGS LA 70739  PT. EMPLOYER: DISABLED BATON ROUGE LA 70805	BILLING	ABSTRACT					
<p><b>NOTICE:</b> THIS IS NOT A BILL. DO NOT PAY. IF IT IS DETERMINED THAT THIS SERVICE OR A PORTION OF THESE SERVICES IS NOT PAYABLE BY YOUR HEALTH PLAN, YOU WILL BE RESPONSIBLE.</p>								
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Date of Posting	Description of Hospital Services	Service Code	Total Charges	Est. Coverage Ins. Co. No. 1	Est. Coverage Ins. Co. No. 2	Est. Coverage Ins. Co. No. 3	Est. Coverage Ins. Co. No. 4	Patient Amount
	BILLING ABSTRACT							
	CONCURRENT GROUPER USED: MC03							
	DRG #: 109 MDC #: 05							
	DRG RATE PER CASE: 20834.96							
	OUTLIER VALUE:							
	GROUPER USED: MC03 (A70)							
	DRG #: 109 MDC #: 05							
	DRG RATE PER CASE: 20834.96							
	OUTLIER VALUE:							
	GROUPER USED: MC03 (ALL)							
	DRG #: 109 MDC #: 05							
	DRG RATE PER CASE: 20834.96							
	OUTLIER VALUE:							
<p><b>NOTICE:</b></p> <p><b>THIS IS NOT A BILL. DO NOT PAY.</b>  <b>IF IT IS DETERMINED THAT THIS SERVICE OR A PORTION OF THESE SERVICES IS NOT PAYABLE BY YOUR HEALTH PLAN, YOU WILL BE RESPONSIBLE.</b></p>								
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BATON ROUGE GENERAL MEDIC  
PO BOX 54376  
NEW ORLEANS LA 701544376  
2258191000

2

3 PATIENT CONTROL NO.

43365725

4 TYPE OF BILL

111

5 FED. TAX NO.

721025017

6 STATEMENT COVERS PERIOD FROM

012104

THROUGH

012504

7 COV D.

004

8 N.C.D.

9 C-I.D.

10 L-R.D.

11 DRG109

T-S

12 PATIENT NAME

DEARIE, DENNIS

13 PATIENT ADDRESS

15431 RED MAPLE PL GREENWELL SPRIN LA 70739

14 DATE 15 SEX 16 MS 17 DATE 18 HR 19 TYPE 20 SRC 21 D HR 22 STAT 23 MEDICAL RECORD NO.

011/1956 M M 012104 05 3 1 13 06 00442263

CONDITION CODES

32 OCCURRENCE DATE 34 OCCURRENCE DATE 36 OCCURRENCE SPAN 37 A B C

DENNIS DEARIE  
15431 RED MAPLE PLACE  
GREENWELL SPRINGS LA 70739

39 CODE 40 VALUE CODES AMOUNT 41 CODE 42 VALUE CODES AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
071	LA MANDATED SRV CHG			4	8 00		
200	INTENSIVE CARE OR (ICU)	1370.00		1	1370 00		
214	CCU/INTERMEDIATE	740.00		3	2220 00		
250	PHARMACY				912 90		
258	IV SOLUTIONS				641 30		
270	MED-SUR SUPPLIES				1669 50		
272	STERILE SUPPLY				12659 50		
301	LAB/CHEMISTRY			17	1483 00		
302	LAB/IMMUNOLOGY			1	327 25		
305	LAB/HEMATOLOGY			13	826 65		
320	DX X-RAY			2	329 75		
360	OR SERVICES			16	9544 00		
370	ANESTHESIA			16	1452 00		
410	RESPIRATORY SVC			1	765 00		
460	PULMONARY FUNC			8	618 00		
001	TOTAL CHARGES				34826 85		

NOTICE:  
THIS IS NOT A BILL. DO NOT PAY.  
IF IT IS DETERMINED THAT THIS  
SERVICE OR A PORTION OF THESE  
SERVICES IS NOT PAYABLE BY  
YOUR HEALTH PLAN, YOU WILL  
BE RESPONSIBLE.

50 PAYER 51 PROVIDER NO. 52 REL INFO 53 ASG BEN 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 T

57 11024212 DUE FROM PATIENT ▶ 58 INSURED'S NAME 59 P.REL 60 CERT. - SSN - HIC - ID NO. 61 GROUP NAME 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES 64 ESC 65 EMPLOYER NAME 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD 68 CODE 69 OTHER PROCEDURE DATE 70 CODE 71 OTHER PROCEDURE DATE 72 CODE 73 ADM. DIAG. CD 74 E-CODE 75

76 ATTENDING PHYS. ID 77 OTHER PHYS. ID 78 OTHER PHYS. ID 79 PROVIDER REPRESENTATIVE 80 DATE

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



# OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER

P.O. Box 14790 • Baton Rouge • LA 70898-4790

\*\* REPRINT \*\* - KSA  
HOSPITAL SERVICES

Patient's Name

Account Number

Admission  
Date

Discharge  
Date

Billing  
Date

DEARIE, DENNIS M

016838070-0304 I 10/30/00 11/14/00 06/05/01

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8972

BILL TO

DENNIS M DEARIE

15431 RED MAPLE PL

GREENWELL SPRINGS LA 70739-3530

**FEDERAL I.D. 72-0423651**

Hospital Has Private Rooms Only

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COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

DEARIE, DENNIS M

Account NBR

016838070-0304

Bill Date

06/05/01

Page No.

001

INSURANCE PORTION IS COMPUTED  
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POSTING  
DATE

REF NBR

DESCRIPTION

TOTAL AMOUNT

INSURANCE  
PORTION

PATIENT  
PORTION

### ----- SUMMARY OF CHARGES -----

### ----- ROOM CHARGES -----

001	PRIVATE		
	15 DAYS AT 390.00	5,850.00	5,850.00
	TOTAL OF ROOM CHARGES	5,850.00	5,850.00

### ----- ANCILLARY CHARGES -----

024	PHARMACY-SPECIAL	145.00	145.00
025	PHARMACY	8,237.89	8,237.89
026	IV THERAPY/SUPPLIES	64.00	64.00
027	CENTRAL SUPPLIES	3,120.90	3,120.90
030	LABORATORY	2,578.75	2,578.75
032	X-RAY SERVICES	6,959.00	6,959.00
035	CT SCAN	2,080.00	2,080.00
036	D.R. SERVICES	1,113.25	1,113.25
042	PHYSICAL MEDICINE	172.00	172.00
066	CARDIOLOGY SERVICES	238.00	238.00
071	RECOVERY ROOM	225.00	225.00
093	OTHER THERAPUTIC SERVICES	108.00	108.00
097	LA MANDATED SERVICE CHARGE	30.00	30.00

TOTAL OF ALL OTHER CHARGES 25,071.79 25,071.79

ACCOUNT ADJUSTMENTS 30.00- 30.00-



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016838070-0304

Bill Date

06/05/01

Page No.

M02

INSURANCE PORTION IS COMPUTED  
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POSTING  
DATE

REF NBR

DESCRIPTION

TOTAL AMOUNT

INSURANCE  
PORTION

PATIENT  
PORTION

TOTAL CHARGES AND INSURANCE

30,891.79

30,921.79

NOTHING DUE AT THIS TIME

30.00-



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Patient's Name	Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
DEARIE, DENNIS M	016838070-0304	06/05/01	1	

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
10/30/00	39200001	PRIVATE	063701	390.00	390.00
10/30/00	75000828	DEX 5% W 50ML		49.12	49.12
		QUANTITY OF 2			
10/30/00	75898874	CEFOXITIN 1GM VIAL	MEFOXIN	46.46	46.46
		QUANTITY OF 2			
10/30/00	81700648	NON IONIC CONTRAST (300) 125	145.00	145.00	
10/30/00	84100015	IV-START/RESTART	32.00	32.00	
10/30/00	40000774	URINAL	1.30	1.30	
10/30/00	40001597	SET, IV EXTENSION 7"	4438	5.30	5.30
10/30/00	40001636	DEX 5% .45% SOD CHL INJ 1000	6.40	6.40	
		QUANTITY OF 2			
10/30/00	40001873	TEMP PROBE COVERS	16.75	16.75	
10/30/00	40002076	ICE BAG	5.15	5.15	
10/30/00	40002202	STOCKING, TED HOSE LARGE/REG	25.75	25.75	
10/30/00	40002343	INSYTE NEEDLE 20G X 1 1/4"	3.20	3.20	
10/30/00	40003790	IV START KIT	5.05	5.05	
10/30/00	40019453	IV SET, SECONDARY	5.75	5.75	
10/30/00	40061842	ADAPTER, CLAVE MALE LL	7.65	7.65	
10/30/00	65107526	CULT BLOOD-ROUTINE ADULT	210.00	210.00	
		QUANTITY OF 2			
10/30/00	65120337	BACTERIAL ID - SINGLE	38.50	38.50	
		QUANTITY OF 2			
10/30/00	65126177	SUSCEPTIBILITY - MIC	23.75	23.75	
10/30/00	81705001	CT-ROOM TIME/QUARTER HOUR	108.00	108.00	
10/30/00	81721938	CT-PELVIS W/ CONTRAST	974.00	974.00	
10/30/00	81741605	CT-ABD W/ CONTRAST	1,106.00	1,106.00	
10/30/00	75317370	CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
10/30/00	75348409	LEVISIN 0.125MG TAB	.95	.95	
10/30/00	75399154	ACETAMINOPHEN 325MG TABLET 2	.20	.20	
10/30/00	75980460	AMITRIPTYLINE 25MG TAB UD	.95	.95	
10/30/00	75991828	DICLOFENAC 75MG TABLET UD	3.31	3.31	
10/30/00	75991894	MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			



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2

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10/30/00	40003777	BEDSIDE KITS	13.25	13.25	
10/31/00	39200001	PRIVATE	390.00	390.00	
10/31/00	81901014	MRI-PARAMAGNETIC CONTR 10 ML	279.00	279.00	
10/31/00	75000018	DEX 5% W 100ML	121.55	121.55	
		QUANTITY OF 5			
10/31/00	75000034	DEX 5% W 250ML	23.50	23.50	
10/31/00	75000661	DEX 5% NACL 0.45% KCL 20MEQ	127.92	127.92	
		QUANTITY OF 3			
10/31/00	75000828	DEX 5% W 50ML	73.68	73.68	
		QUANTITY OF 3			
10/31/00	75108431	NAFCILLIN 2GM VIAL	79.85	79.85	
		QUANTITY OF 5			
10/31/00	75124156	MEPERIDINE 50MG VIAL	72.00	72.00	
		QUANTITY OF 8			
10/31/00	75124206	MEPERIDINE 100MG/1ML VIAL	9.00	9.00	
10/31/00	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	53.95	53.95	
		QUANTITY OF 5			
10/31/00	75780001	LEVOFLOXACIN 500MG IN D5W100	158.40	158.40	
		QUANTITY OF 2			
10/31/00	75780207	POTASSIUM CL RIDER 40MEQ/100	20.32	20.32	
10/31/00	75898874	CEFOXITIN 1GM VIAL MEFOXIN	69.69	69.69	
		QUANTITY OF 3			
10/31/00	75992469	VANCOMYCIN 1000MG VIAL	39.63	39.63	
10/31/00	40002344	INSYTE NEEDLE 22G X 1"	3.35	3.35	
10/31/00	40003790	IV START KIT	5.05	5.05	
10/31/00	65004954	POTASSIUM-SERUM	36.25	36.25	
10/31/00	65005456	COMPREHENSIVE METABOLIC PANE	131.00	131.00	
10/31/00	65301115	CBC WITH MANUAL DIFF	57.00	57.00	
10/31/00	65305500	SED RATE	23.75	23.75	
10/31/00	81901020	MRI-THORACIC SPINE W/WD CONTR	2,420.00	2,420.00	
10/31/00	81901022	MRI-LUMBAR SPINE W/WD CONTRA	1,877.00	1,877.00	
10/31/00	75300186	ACETAMINOPHEN 500MG CAPLETS	.40	.40	
		QUANTITY OF 2			



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Patient's Name	Account Number	Admission Date	Discharge Date	Billing Date
DEARIE, DENNIS M	016838070-0304 I	10/30/00	11/14/00	06/05/01

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Patient's Name	Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
DEARIE, DENNIS M	016838070-0304	06/05/01	3	

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
10/31/00	75317370	CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
10/31/00	75348409	LEVSIN 0.125MG TAB	.95	.95	
10/31/00	75399154	ACETAMINOPHEN 325MG TABLET 2	1.60	1.60	
		QUANTITY OF 8			
10/31/00	75980460	AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
10/31/00	75991928	DICLOFENAC 75MG TABLET UD	3.31	3.31	
10/31/00	75991894	MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/01/00	39200001	PRIVATE	063701	390.00	390.00
11/01/00	75000018	DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
11/01/00	75000182	DEXTROSE 5% / NACL 0.45% 100	89.97	89.97	
		QUANTITY OF 3			
11/01/00	75000281	SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/01/00	75000661	DEX 5% NACL 0.45% KCL 20MEQ	42.64	42.64	
11/01/00	75108431	NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/01/00	75124206	MEPERIDINE 100MG/1ML VIAL	63.00	63.00	
		QUANTITY OF 7			
11/01/00	75237750	GENTAMICIN 80MG/2ML VIAL	24.00	24.00	
		QUANTITY OF 3			
11/01/00	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	64.74	64.74	
		QUANTITY OF 6			
11/01/00	75272500	POTASSIUM CHLORIDE 40MEQ/20M	24.00	24.00	
		QUANTITY OF 3			
11/01/00	75780001	LEVOFLOXACIN 500MG IN D5W100	79.20	79.20	
11/01/00	75780207	POTASSIUM CL RIDER 40MEQ/100	20.32	20.32	
11/01/00	75992482	FENTANYL 25MCG/HR PATCH 1 EA	25.38	25.38	
11/01/00	84100015	IV-START/RESTART	32.00	32.00	
11/01/00	40000048	DRESSING, TEGADERM 2.38X2.75	1.15	1.15	
11/01/00	40000127	SPONGE, GAUZE 4X4 10/PK 16PL	2.00	2.00	
11/01/00	40000169	TAPE 1" CLEAR	3.10	3.10	





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4

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11/01/0040001058		KIT, CATHETER DUAL LUMEN ARR	48.50	48.50	
11/01/0040001597		SET, IV EXTENSION 7" 4438	5.30	5.30	
11/01/0040002344		INSYTE NEEDLE 22G X 1"	3.35	3.35	
11/01/0040003790		IV START KIT	5.05	5.05	
11/01/0040019459		IV SET, PRIMARY W/O FILTER	10.00	10.00	
11/01/0040061842		ADAPTER, CLAVE MALE LL	22.95	22.95	
		QUANTITY OF 3			
11/01/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/01/0065004459		MAGNESIUM-SERUM	60.00	60.00	
11/01/0065005450		METABOLIC PANEL	124.00	124.00	
11/01/0065107526		CULT BLOOD-ROUTINE ADULT	210.00	210.00	
		QUANTITY OF 2			
11/01/0065120337		BACTERIAL ID - SINGLE	38.50	38.50	
		QUANTITY OF 2			
11/01/0065301105		CBC WITH AUTO DIFF	48.25	48.25	
11/01/0080002074		SINGLE VIEW CHEST	87.00	87.00	
11/01/0082000025		MINOR PROCEDURE (RR)	173.25	173.25	
		QUANTITY OF 55			
11/01/0093402412		ECHOCARDIOGRAM	238.00	238.00	
11/01/0092001058		CARDIAC MONITOR UP TO 4 HRS	24.00	24.00	
11/01/0082001553		DINAMAP MONITOR	24.00	24.00	
11/01/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/01/0075348409		LEVSIIN 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
11/01/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/01/0075991584		LISINAPRIL 10MG TABLET UD	2.15	2.15	
11/01/0075991828		DICLOFENAC 75MG TABLET UD	6.62	6.62	
		QUANTITY OF 2			
11/01/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/02/0039200001		PRIVATE	063701 390.00	390.00	



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Patient's Name: DEARIE, DENNIS M Account NBR: 016838070-0304 Bill Date: 06/05/01 Page No: 5

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11/02/0075000018	DEX 5% W 100ML	QUANTITY OF 6	145.86	145.86	
11/02/0075000034	DEX 5% W 250ML		23.50	23.50	
11/02/0075000182	DEXTROSE 5% / NACL 0.45% 100	QUANTITY OF 3	89.97	89.97	
11/02/0075108431	NAFCILLIN 2GM VIAL	QUANTITY OF 6	95.82	95.82	
11/02/0075124206	MEPERIDINE 100MG/1ML VIAL	QUANTITY OF 6	54.00	54.00	
11/02/0075243907	DROPERIDOL 2.5MG/ML 2ML AMP	QUANTITY OF 6	64.74	64.74	
11/02/0075272500	POTASSIUM CHLORIDE 40MEQ/20M	QUANTITY OF 4	32.00	32.00	
11/02/0075780001	LEVOFLOXACIN 500MG IN D5W100		79.20	79.20	
11/02/0075991932	MEPERIDINE 10MG/ML IN NS 100		63.50	63.50	
11/02/0040001683	SOD CHL .9% INJ 250ML		2.55	2.55	
11/02/0040019453	IV SET, SECONDARY		5.75	5.75	
11/02/0040019459	IV SET, PRIMARY W/O FILTER		10.00	10.00	
11/02/0040006021	SET, PCA TUBING		33.50	33.50	
11/02/0052009623	IV PUMP 2 CHANNEL		57.00	57.00	
11/02/0052060221	PUMP, PCA		72.00	72.00	
11/02/0065005450	METABOLIC PANEL		124.00	124.00	
11/02/0065016073	GENTAMICIN TROUGH-SERUM		66.00	66.00	
11/02/0080006653	ABDOMEN FLAT AND ERECT		215.00	215.00	
11/02/0075317370	CLONAZEPAM 0.5MG TABLET UD		1.99	1.99	
11/02/0075348409	LEVYSIN 0.125MG TAB	QUANTITY OF 2	1.90	1.90	
11/02/0075980460	AMITRIPTYLINE 25MG TAB UD	QUANTITY OF 2	1.90	1.90	
11/02/0075981068	HYDROCODONE/ACETAMINOPHEN 5/	QUANTITY OF 2	5.00	5.00	
11/02/0075991584	LISINAPRIL 10MG TABLET UD		2.15	2.15	



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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/02/00	75991828	DICLOFENAC 75MG TABLET UD QUANTITY OF 2	6.62	6.62	
11/02/00	75991894	MISOPROSTOL 200MCG TABLET UD QUANTITY OF 3	5.64	5.64	
11/03/00	39200001	PRIVATE 063701	390.00	390.00	
11/03/00	75000018	DEX 5% W 100ML QUANTITY OF 7	170.17	170.17	
11/03/00	75000182	DEXTROSE 5% / NACL 0.45% 100 QUANTITY OF 2	59.98	59.98	
11/03/00	75108431	NAFCILLIN 2GM VIAL QUANTITY OF 7	111.79	111.79	
11/03/00	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
11/03/00	75272500	POTASSIUM CHLORIDE 40MEQ/20M QUANTITY OF 2	16.00	16.00	
11/03/00	75780001	LEVOFLOXACIN 500MG IN D5W100	79.20	79.20	
11/03/00	75808143	HEPARIN 100 UNITS/ML 10ML VI	8.00	8.00	
11/03/00	40001969	BASIN, EMESIS	.85	.85	
11/03/00	40019452	IV SET, PRIMARY W/FILTER	15.00	15.00	
11/03/00	52009623	IV PUMP 2 CHANNEL	57.00	57.00	
11/03/00	52060221	PUMP, PCA	72.00	72.00	
11/03/00	65005450	METABOLIC PANEL	124.00	124.00	
11/03/00	65107526	CULT BLOOD-ROUTINE ADULT QUANTITY OF 2	210.00	210.00	
11/03/00	75317370	CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/03/00	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	1.90	1.90	
11/03/00	75980460	AMITRIPTYLINE 25MG TAB UD QUANTITY OF 2	1.90	1.90	
11/03/00	75991584	LISINAPRIL 10MG TABLET UD	2.15	2.15	
11/03/00	75991828	DICLOFENAC 75MG TABLET UD QUANTITY OF 2	6.62	6.62	
11/03/00	75991894	MISOPROSTOL 200MCG TABLET UD QUANTITY OF 2	3.76	3.76	



# OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER

P.O. Box 14790 • Baton Rouge • LA 70898-4790

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HOSPITAL SERVICES

Patient's Name <b>DEARIE, DENNIS M</b>	Account Number <b>016838070-0304 I</b>	Admission Date <b>10/30/00</b>	Discharge Date <b>11/14/00</b>	Billing Date <b>06/05/01</b>
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PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO

DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWELL SPRINGS LA 70739-3530

**FEDERAL I.D. 72-0423651**

Hospital Has Private Rooms Only

IMPORTANT: PLEASE DETACH AND RETURN THE TOP PORTION OF THIS  
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COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name <b>DEARIE, DENNIS M</b>	Account NBR <b>016838070-0304</b>	Bill Date <b>06/05/01</b>	Page No. <b>7</b>	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/04/0039200001		PRIVATE	063701	390.00	390.00
11/04/0075000018		DEX 5% W 100ML		194.48	194.48
		QUANTITY OF 8			
11/04/0075000182		DEXTROSE 5% / NA CL 0.45% 100		89.97	89.97
		QUANTITY OF 3			
11/04/0075000281		SODIUM CHLORIDE 0.9% 150ML		20.00	20.00
11/04/0075108431		NAFCILLIN 2GM VIAL		127.76	127.76
		QUANTITY OF 8			
11/04/0075237750		GENTAMICIN 80MG/2ML VIAL		24.00	24.00
		QUANTITY OF 3			
11/04/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP		10.79	10.79
11/04/0075272500		POTASSIUM CHLORIDE 40MEQ/20M		24.00	24.00
		QUANTITY OF 3			
11/04/0075780001		LEV OFLOXACIN 500MG IN D5W100		79.20	79.20
11/04/0075991932		MEPERIDINE 10MG/ML IN NS 100		63.50	63.50
11/04/0075992484		FENTANYL 50MCG/HR PATCH 1 EA		38.05	38.05
11/04/0040003831		SUBCLAVIAN DRESSING KITS		11.75	11.75
11/04/0052009623		IV PUMP 2 CHANNEL		57.00	57.00
11/04/0052060221		PUMP, PCA		72.00	72.00
11/04/0065005450		METABOLIC PANEL		124.00	124.00
11/04/0065301105		CBC WITH AUTO DIFF		48.25	48.25
11/04/0075317370		CLONAZEPAM 0.5MG TABLET UD		1.99	1.99
11/04/0075348409		LEV SIN 0.125MG TAB		1.90	1.90
		QUANTITY OF 2			
11/04/0075980460		AMITRIPTYLINE 25MG TAB UD		1.90	1.90
		QUANTITY OF 2			
11/04/0075991584		LISINAPRIL 10MG TABLET UD		2.15	2.15
11/04/0075991828		DICLOFENAC 75MG TABLET UD		6.62	6.62
		QUANTITY OF 2			
11/04/0075991894		MISOPROSTOL 200MCG TABLET UD		1.88	1.88
11/05/0039200001		PRIVATE	063701	390.00	390.00
11/05/0075000018		DEX 5% W 100ML		145.86	145.86
		QUANTITY OF 6			



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Page No.

8

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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/05/00750001820		EXTROSE 5% / NACL 0.45% 100 QUANTITY OF 2	59.98	59.98	
11/05/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/05/0075108431		NAFCILLIN 2GM VIAL QUANTITY OF 6	95.82	95.82	
11/05/0075237750		GENTAMICIN 80MG/2ML VIAL QUANTITY OF 3	24.00	24.00	
11/05/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
11/05/0075272500		POTASSIUM CHLORIDE 40MEQ/20M QUANTITY OF 2	16.00	16.00	
11/05/0075780001		LEVOFLOXACIN 500MG IN D5W100	79.20	79.20	
11/05/0075808143		HEPARIN 100 UNITS/ML 10ML VI	8.00	8.00	
11/05/0075991932		MEPERIDINE 10MG/ML IN NS 100	63.50	63.50	
11/05/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/05/0052060221		PUMP, PCA	72.00	72.00	
11/05/0065301115		CBC WITH MANUAL DIFF	57.00	57.00	
11/05/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/05/0075348409		LEV SIN 0.125MG TAB QUANTITY OF 2	1.90	1.90	
11/05/0075399154		ACETAMINOPHEN 325MG TABLET 2 QUANTITY OF 6	1.20	1.20	
11/05/0075980460		AMITRIPTYLINE 25MG TAB UD QUANTITY OF 2	1.90	1.90	
11/05/0075991584		LISINAPRIL 10MG TABLET UD QUANTITY OF 2	4.30	4.30	
11/05/0075991828		DICLOFENAC 75MG TABLET UD QUANTITY OF 2	6.62	6.62	
11/06/0039200001		PRIVATE 063701	390.00	390.00	
11/06/0081901014		MRI-PARAMAGNETIC CONTR 10 ML	279.00	279.00	
11/06/0075000018		DEX 5% W 100ML QUANTITY OF 6	145.86	145.86	
11/06/0075000182		DEXTROSE 5% / NACL 0.45% 100 QUANTITY OF 2	59.98	59.98	



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DEARIE, DENNIS M		016838070-0304		06/05/01	9		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION		
11/06/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00			
11/06/0075108431		NAFCILLIN 2GM VIAL	95.82	95.82			
		QUANTITY OF 6					
11/06/0075237750		GENTAMICIN 80MG/2ML VIAL	24.00	24.00			
		QUANTITY OF 3					
11/06/0075272500		POTASSIUM CHLORIDE 40MEQ/20M	16.00	16.00			
		QUANTITY OF 2					
11/06/0075808143		HEPARIN 100 UNITS/ML 10ML VI	8.00	8.00			
11/06/0075992484		FENTANYL 50MCG/HR PATCH 1 EA	38.05	38.05			
11/06/0040000169		TAPE 1" CLEAR	3.10	3.10			
11/06/0040019452		IV SET, PRIMARY W/FILTER	15.00	15.00			
11/06/0040019453		IV SET, SECONDARY	5.75	5.75			
11/06/0052009623		IV PUMP 2 CHANNEL	57.00	57.00			
11/06/0052060221		PUMP, PCA	72.00	72.00			
11/06/0081901022		MRI-LUMBAR SPINE W/WD CONTRA	1,877.00	1,877.00			
11/06/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99			
11/06/0075348409		LEVSI 0.125MG TAB	1.90	1.90			
		QUANTITY OF 2					
11/06/0075399154		ACETAMINOPHEN 325MG TABLET 2	.80	.80			
		QUANTITY OF 4					
11/06/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90			
		QUANTITY OF 2					
11/06/0075991584		LISINAPRIL 10MG TABLET UD	4.30	4.30			
		QUANTITY OF 2					
11/06/0075991826		DICLOFENAC 75MG TABLET UD	6.62	6.62			
		QUANTITY OF 2					
11/06/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76			
		QUANTITY OF 2					
11/07/0039200001		PRIVATE	063701	390.00	390.00		
11/07/0075000018		DEX 5% W 100ML	145.86	145.86			
		QUANTITY OF 0					
11/07/0075000182		DEXTRUSE 5% / NACL 0.45% 100	89.97	89.97			
		QUANTITY OF 3					



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Page No.

10

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11/07/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/07/0075108431		NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/07/0075124156		MEPERIDINE 50MG VIAL	9.00	9.00	
11/07/0075237750		GENTAMICIN 80MG/2ML VIAL	24.00	24.00	
		QUANTITY OF 3			
11/07/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
11/07/0075272500		POTASSIUM CHLORIDE 40MEQ/20M	24.00	24.00	
		QUANTITY OF 3			
11/07/0075991932		MEPERIDINE 10MG/ML IN NS 100	63.50	63.50	
11/07/0075992488		FENTANYL 100MCG/HR PATCH 1 E	72.42	72.42	
11/07/0040003831		SUBCLAVIAN DRESSING KITS	11.75	11.75	
11/07/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/07/0052060221		PUMP, PCA	72.00	72.00	
11/07/0065301105		CBC WITH AUTO DIFF	48.25	48.25	
11/07/0065305500		SED RATE	23.75	23.75	
11/07/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/07/0075348409		LEVSI 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
11/07/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/07/0075991584		LISINAPRIL 10MG TABLET UD	4.30	4.30	
		QUANTITY OF 2			
11/07/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/08/0039200001		PRIVATE	390.00	390.00	
11/08/0075000018		DEX 5% W 100ML	121.55	121.55	
		QUANTITY OF 5			
11/08/0075000182		DEXTROSE 5% / NACL 0.45% 100	59.98	59.98	
		QUANTITY OF 2			
11/08/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/08/0075108431		NAFCILLIN 2GM VIAL	79.85	79.85	
		QUANTITY OF 5			



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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/08/0075237750		GENTAMICIN 80MG/2ML VIAL QUANTITY OF 3	24.00	24.00	
11/08/0075272500		POTASSIUM CHLORIDE 40MEQ/20M QUANTITY OF 2	16.00	16.00	
11/08/0075808143		HEPARIN 100 UNITS/ML 10ML VI	8.00	8.00	
11/08/0040003831		SURCLAVIAN DRESSING KITS	11.75	11.75	
11/08/0040019452		IV SET, PRIMARY W/FILTER	15.00	15.00	
11/08/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/08/0052060221		PUMP, PCA	72.00	72.00	
11/08/0075300202		RIFAMPIN 300MG CAP QUANTITY OF 2	10.72	10.72	
11/08/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/08/0075348409		LEVSI 0.125MG TAB QUANTITY OF 2	1.90	1.90	
11/08/0075980460		AMITRIPTYLINE 25MG TAB UD QUANTITY OF 2	1.90	1.90	
11/08/0075991828		DICLOFENAC 75MG TABLET UD	3.31	3.31	
11/08/0075991894		MISOPROSTOL 200MCG TABLET UD	1.88	1.88	
11/09/0039200001		PRIVATE - 063701	390.00	390.00	
11/09/0075000018		DEX 5% W 100ML QUANTITY OF 7	170.17	170.17	
11/09/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/09/0075108431		NAFCILLIN 2GM VIAL QUANTITY OF 7	111.79	111.79	
11/09/0075237750		GENTAMICIN 80MG/2ML VIAL QUANTITY OF 3	24.00	24.00	
11/09/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP QUANTITY OF 2	21.58	21.58	
11/09/0075808143		HEPARIN 100 UNITS/ML 10ML VI	8.00	8.00	
11/09/0075991932		MEPERIDINE 10MG/ML IN NS 100	63.50	63.50	
11/09/0040019452		IV SET, PRIMARY W/FILTER	15.00	15.00	
11/09/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/09/0052060221		PUMP, PCA	72.00	72.00	





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12

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11/09/0065005450		METABOLIC PANEL	124.00	124.00	
11/09/0065107526		CULT BLOOD-ROUTINE ADULT	210.00	210.00	
		QUANTITY OF 2			
11/09/0065301105		CBC WITH AUTO DIFF	48.25	48.25	
11/09/0075300202		RIFAMPIN 300MG CAP	10.72	10.72	
		QUANTITY OF 2			
11/09/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/09/0075348409		LEV.SIN 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
11/09/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/09/0075991584		LISINAPRIL 10MG TABLET UD	4.30	4.30	
		QUANTITY OF 2			
11/09/0075991828		DICLOFENAC 75MG TABLET UD	6.62	6.62	
		QUANTITY OF 2			
11/09/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/10/0039200001		PRIVATE	390.00	390.00	
11/10/0075000018		DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
11/10/0075000182		DEXTROSE 5% / NACL 0.45% 100	29.99	29.99	
11/10/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/10/0075100057		FENTANYL 0.05MG/ML 5ML AMP	9.00	9.00	
11/10/0075108431		NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/10/0075203034		LIDOCAINE 2% (100MG/5ML) 5ML	8.00	8.00	
11/10/0075237750		GENTAMICIN 80MG/2ML VIAL	24.00	24.00	
		QUANTITY OF 3			
11/10/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
11/10/0075272500		POTASSIUM CHLORIDE 40MEQ/20M	8.00	8.00	
11/10/0075279869		METOCLOPRAMIDE 10MG/2ML VIAL	8.00	8.00	
11/10/0075992358		SODIUM CHLORIDE .9% SDV 20ML	8.00	8.00	
11/10/0075992512		MIDAZOLAM 1MG/ML 2ML MDV	11.01	11.01	

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Patient's Name <b>DEARIE, DENNIS M</b>	Account Number <b>016838070-0304 I</b>	Admission Date <b>10/30/00</b>	Discharge Date <b>11/14/00</b>	Billing Date <b>06/05/01</b>
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BILL TO

**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWELL SPRINGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

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COMPENSATION

C07

# INSURANCE BENEFITS ASSIGNED

Patient's Name <b>DEARIE, DENNIS M</b>	Account NBR <b>016838070-0304</b>	Bill Date <b>06/05/01</b>	Page No. <b>13</b>	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/10/00759925230		DANDANSETRON 2MG/ML (1ML CHAR	57.18	57.18	
11/10/0075992582		PROPOFOL 10MG/ML IV EMULSION	31.38	31.38	
11/10/0040000048		DRESSING, TEGADERM 2.38X2.75	1.15	1.15	
11/10/0040000049		DRESSING, TEGADERM 4"X4"	3.60	3.60	
11/10/0040000146		SPONGE, DRESS SOF-WICK 4X4	.85	.85	
11/10/0040000150		SPONGE, SURGICEL 4 X 8	77.00	77.00	
11/10/0040000303		POSITIONER, DONUT AID	3.55	3.55	
11/10/0040000342		POSITIONER, PROTECTOR ELBOW	8.45	8.45	
11/10/0040001269		GLOVE, ULTRADERM BROWN 6.5	7.90	7.90	
11/10/0040001271		GLOVE, ULTRADERM BROWN 7.5	7.95	7.95	
11/10/0040001668		LACTATED RINGERS INJ USP 100	3.35	3.35	
11/10/0040001710		SOLUTION, IRRIGATE N/S BT 500	3.40	3.40	
11/10/0040001841		PAD, ELECTRODE RETURN ADULT	11.50	11.50	
11/10/0040002273		VASELINE JELLY 1 OZ TUBE	2.60	2.60	
11/10/0040002784		SUTURE, ETHILON 2 LR-LR 75CM	11.25	11.25	
11/10/0040003831		SUBCLAVIAN DRESSING KITS	11.75	11.75	
11/10/0040003838		INSTRUMENT SET DISPOSABLE	19.75	19.75	
11/10/0040006457		SOLUTION, DURAPREP	21.00	21.00	
11/10/0040009921		PACK, MAJOR-SURGERY	86.00	86.00	
11/10/0040019453		IV SET, SECONDARY	5.75	5.75	
11/10/0040019502		GLOVE, BIOGEL WHITE 7	13.20	13.20	
		QUANTITY OF 2			
11/10/0040019628		CATH, HICKMAN SINGLE LUMEN 9	106.00	106.00	
11/10/0040025438		MONDCRYL 4-0 PS-2	14.50	14.50	
11/10/0040050359		BOVIE OR VAL LAB	9.45	9.45	
11/10/0040059254		DRAPE, LAP VHA+	23.25	23.25	
11/10/0040061842		ADAPTER, CLAVE MALE LL	7.65	7.65	
11/10/0050016841		SENSOR GUARD BANDAGE, ADULT	5.30	5.30	
11/10/0050025497		FLEXISENSOR, ADULT	6.00	6.00	
11/10/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/10/0052060221		PUMP, PCA	72.00	72.00	
11/10/0080002074		SINGLE VIEW CHEST	87.00	87.00	
11/10/0080009806		FLUOROSCOPY GREATER THAN 1 H	396.00	396.00	



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Patient's Name

DEARIE, DENNIS M

Account Number

016838070-0304 I

Admission Date

10/30/00

Discharge Date

11/14/00

Billing Date

06/05/01

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COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

DEARIE, DENNIS M

Account NBR

016838070-0304

Bill Date

06/05/01

Page No.

14

INSURANCE PORTION IS COMPUTED  
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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/10/00	70000007	SURGERY MINUTES	940.00	940.00	
		QUANTITY OF 47			
11/10/00	50000782	ANES. MONITORING CHARGE	251.00	251.00	
11/10/00	40055967	SHEATH, 10-12 FR, PEEL AWAY	112.00	112.00	
11/10/00	82000021	RECOVERY ROOM MINUTES-2	225.00	225.00	
		QUANTITY OF 50			
11/10/00	82001058	CARDIAC MONITOR UP TO 4 HRS	24.00	24.00	
11/10/00	82001553	DINAMAP MONITOR	24.00	24.00	
11/10/00	75300202	RIFAMPIN 300MG CAP	5.36	5.36	
11/10/00	75317370	CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/10/00	75348409	LEVSIN 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
11/10/00	75399154	ACETAMINOPHEN 325MG TABLET 2	.40	.40	
		QUANTITY OF 2			
11/10/00	75980460	AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/10/00	75991584	LISINAPRIL 10MG TABLET UD	4.30	4.30	
		QUANTITY OF 2			
11/10/00	75991828	DICLOFENAC 75MG TABLET UD	6.62	6.62	
		QUANTITY OF 2			
11/10/00	75991894	MISOPROSTOL 200MCG TABLET UD	1.88	1.88	
11/11/00	39200001	PRIVATE	390.00	390.00	
		063701			
11/11/00	75000018	DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
11/11/00	75000182	DEXTROSE 5% / NACL 0.45% 100	29.99	29.99	
11/11/00	75000281	SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/11/00	75108431	NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/11/00	75237750	GENTAMICIN 80MG/2ML VIAL	24.00	24.00	
		QUANTITY OF 3			
11/11/00	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	21.58	21.58	
		QUANTITY OF 2			
11/11/00	75272500	POTASSIUM CHLORIDE 40MEQ/20M	8.00	8.00	



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**HOSPITAL SERVICES**

Patient's Name <b>DEARIE, DENNIS M</b>	Account Number <b>016838070-0304 I</b>	Admission Date <b>10/30/00</b>	Discharge Date <b>11/14/00</b>	Billing Date <b>06/05/01</b>
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Patient's Name <b>DEARIE, DENNIS M</b>	Account NBR <b>016838070-0304</b>	Bill Date <b>06/05/01</b>	Page No. <b>15</b>	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/11/0075991932		MEPERIDINE 10MG/ML IN NS 100	63.50	63.50	
11/11/0040000048		DRESSING, TEGADERM 2.38X2.75	1.15	1.15	
11/11/0040002202		STOCKING, TED HOSE LARGE/REG	25.75	25.75	
11/11/0040003831		SUBCLAVIAN DRESSING KITS	11.75	11.75	
11/11/0040019452		IV SET, PRIMARY W/FILTER	30.00	30.00	
		QUANTITY OF 2			
11/11/0040019453		IV SET, SECONDARY	5.75	5.75	
11/11/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/11/0052060221		PUMP, PCA	72.00	72.00	
11/11/0077001469		PT EVALUATION	172.00	172.00	
11/11/0075300202		RIFAMPIN 300MG CAP	10.72	10.72	
		QUANTITY OF .2			
11/11/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/11/0075348409		LEVSIN 0.125MG TAB	.95	.95	
11/11/0075399154		ACETAMINOPHEN 325MG TABLET 2	.40	.40	
		QUANTITY OF 2			
11/11/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/11/0075991584		LISINOPRIL 10MG TABLET UD	34.40	34.40	
		QUANTITY OF 16			
11/11/0075991828		DICLOFENAC 75MG TABLET UD	3.31	3.31	
11/11/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/12/0039200001		PRIVATE	390.00	390.00	
11/12/0075000018		DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
11/12/0075000182		DEXTROSE 5% / NACL 0.45% 100	29.99	29.99	
11/12/0075000281		SODIUM CHLORIDE 0.9% 150ML	20.00	20.00	
11/12/0075108431		NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/12/0075237750		GENTAMICIN 80MG/2ML VIAL	24.00	24.00	
		QUANTITY OF 3			



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DEARIE, DENNIS M

Account NBR

016838070-0304

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06/05/01

Page No.

16

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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/12/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP QUANTITY OF 2	21.58	21.58	
11/12/0075272500		POTASSIUM CHLORIDE 40MEQ/20M	8.00	8.00	
11/12/0040003831		SUBCLAVIAN DRESSING KITS	11.75	11.75	
11/12/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/12/0052060221		PUMP, PCA	72.00	72.00	
11/12/0075300202		RIFAMPIN 300MG CAP QUANTITY OF 3	16.08	16.08	
11/12/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/12/0075348409		LEVSI 0.125MG TAB QUANTITY OF 2	1.90	1.90	
11/12/0075399154		ACETAMINOPHEN 325MG TABLET 2 QUANTITY OF 3	.60	.60	
11/12/0075980460		AMITRIPTYLINE 25MG TAB UD QUANTITY OF 2	1.90	1.90	
11/12/0075991584		LISINAPRIL 10MG TABLET UD QUANTITY OF 2	4.30	4.30	
11/12/0075991828		DICLOFENAC 75MG TABLET UD QUANTITY OF 2	6.62	6.62	
11/12/0075991894		MISOPROSTOL 200MCG TABLET UD QUANTITY OF 2	3.76	3.76	
11/13/0039200001		PRIVATE			
11/13/00750000180		EX 5% W 100ML QUANTITY OF 2	48.62	48.62	
11/13/0075108431		NAFCILLIN 2GM VIAL QUANTITY OF 2	31.94	31.94	
11/13/0075243907		DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
11/13/0075780207		POTASSIUM CL RIDER 40MEQ/100 QUANTITY OF 2	40.64	40.64	
11/13/0040000182		TAPE, SILK 1" DURAPORE	2.30	2.30	
11/13/0040019453		IV SET, SECONDARY	5.75	5.75	
11/13/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/13/0052060221		PUMP, PCA	72.00	72.00	



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Patient's Name <b>DEARIE, DENNIS M</b>	Account NBR <b>016838070-0304</b>	Bill Date <b>06/05/01</b>	Page No. <b>17</b>	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/13/0065005456		COMPREHENSIVE METABOLIC PANE	131.00	131.00	
11/13/0065301105		CBC WITH AUTO DIFF	48.25	48.25	
11/13/0075300202		RIFAMPIN 300MG CAP	16.08	16.08	
		QUANTITY OF 3			
11/13/0075317370		CLONAZEPAM 0.5MG TABLET UD	1.99	1.99	
11/13/0075348409		LEVSIN 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
11/13/0075780310		ZALEPLON 5MG CAPSULE	3.44	3.44	
11/13/0075980460		AMITRIPTYLINE 25MG TAB UD	1.90	1.90	
		QUANTITY OF 2			
11/13/0075991584		LISINAPRIL 10MG TABLET UD	4.30	4.30	
		QUANTITY OF 2			
11/13/0075991828		DICLOFENAC 75MG TABLET UD	6.62	6.62	
		QUANTITY OF 2			
11/13/0075991894		MISOPROSTOL 200MCG TABLET UD	3.76	3.76	
		QUANTITY OF 2			
11/14/0075000018		DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
11/14/0075000182		DEXTROSE 5% / NACL 0.45% 100	29.99	29.99	
11/14/0075108431		NAFCILLIN 2GM VIAL	95.82	95.82	
		QUANTITY OF 6			
11/14/0075272500		POTASSIUM CHLORIDE 40MEQ/20M	8.00	8.00	
11/14/0040003831		SUBCLAVIAN DRESSING KITS	11.75	11.75	
11/14/0052009623		IV PUMP 2 CHANNEL	57.00	57.00	
11/14/0052060221		PUMP, PCA	72.00	72.00	
11/14/0065004459		MAGNESIUM-SERUM	60.00	60.00	
11/14/0065005456		COMPREHENSIVE METABOLIC PANE	131.00	131.00	
11/14/0075300202		RIFAMPIN 300MG CAP	5.36	5.36	
11/14/0075348409		LEVSIN 0.125MG TAB	.95	.95	
11/14/0075991584		LISINAPRIL 10MG TABLET UD	4.30	4.30	
		QUANTITY OF 2			
11/14/0075991828		DICLOFENAC 75MG TABLET UD	3.31	3.31	
11/14/0075991894		MISOPROSTOL 200MCG TABLET UD	1.88	1.88	



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POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
11/17/00	39910911	LA MANDATED SERVICE CHG IP QUANTITY OF 15	30.00	30.00	
		SUB-TOTAL OF CHARGES	30,921.79	30,921.79	
11/17/00	000114151	LA MANDATED SERV CHG WRITEOFF PAID BY LA MANDATED CHG /			30.00-
		TOTAL PAYMENTS AND ADJUSTMENTS			30.00-
		TOTAL CHARGES AND INSURANCE	30,891.79	30,921.79	
		NOTHING DUE AT THIS TIME			30.00-



**PATHOLOGY GROUP OF LOUISIANA**  
A PROFESSIONAL MEDICAL CORPORATION  
P.O. BOX  
BATON ROUGE, LOUISIANA 70884  
(225) 769-9993 885-3506 S5 P1

IF PAYING BY CREDIT CARD FILL OUT BELOW



Exp. Date: \_\_\_\_\_

Card # \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

STATEMENT DATE

PAY THIS AMOUNT

ACCT. #

11/19/2000

\$773.00

L16838070

Page # 1

SHOW AMOUNT  
PAID HERE \$

REMIT TO:

PATHOLOGY GROUP OF LOUISIANA  
P.O. BOX 84030  
BATON ROUGE, LA 70884-4030

DENNIS DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS LA 707393530



☐ Please check box if above address is incorrect. Indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	CODE	DESCRIPTION	AMOUNT
10/28/00	85007	BLOOD COUNT MANUAL DIFFERENTIAL WBC	6.00
10/28/00	80048	BASIC METABOLIC PANEL	19.00
10/28/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
10/28/00	81000	URINALYSIS WITH MICROSCOPY	6.00
10/28/00	82150	AMYLASE	11.00
10/28/00	83690	LIPASE	8.00
10/28/00	80076	HEPATIC FUNCTION PANEL	23.00
10/28/00	87086	CULTURE BACTERIAL URINE QUANTITATIVE	11.00
10/28/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
10/28/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
10/28/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/28/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/28/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/28/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/28/00	87186	ANTIBIOTIC SENSITIVITY MIC	12.00
10/28/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/30/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
10/30/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
10/31/00	80053	COMPREHENSIVE METABOLIC	21.00
10/31/00	84132	POTASSIUM SERUM	7.00
10/31/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
10/31/00	85651	SEDIMENT RATE ERYTHROCYTE NON AUTOMA	6.00
10/30/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
11/01/00	80048	BASIC METABOLIC PANEL	19.00
11/01/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/01/00	83735	MAGNESIUM	12.00
11/01/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
11/01/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
10/30/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
10/30/00	87186	ANTIBIOTIC SENSITIVITY MIC	12.00
11/02/00	80048	BASIC METABOLIC PANEL	19.00
11/02/00	80170	GENTAMICIN	17.00
11/01/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
11/01/00	87797	INFECTIOUS AGENT DETECT NUCLEIC ACID	20.00
11/03/00	80048	BASIC METABOLIC PANEL	19.00
11/03/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
11/03/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
11/04/00	80048	BASIC METABOLIC PANEL	19.00
11/04/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/05/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/05/00	85060	BLOOD SMEAR PERIPHERAL W/PHYS REPORT	25.00

12/5/00

Debra  
Charged  
Raven

STATEMENT



**PATHOLOGY GROUP OF LOUISIANA**  
A PROFESSIONAL MEDICAL CORPORATION  
P.O. BOX  
BATON ROUGE, LOUISIANA 70884  
(225) 769-9993 885-3506 S5 P1

IF PAYING BY CREDIT CARD FILL OUT BELOW

☐ VISA ☐ MasterCard Exp. Date: \_\_\_\_\_  
Card # \_\_\_\_\_  
Signature: \_\_\_\_\_  
Name of Cardholder: \_\_\_\_\_

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/19/2000	\$773.00	L16838070

Page # 2 SHOW AMOUNT PAID HERE \$

**REMIT TO:**

PATHOLOGY GROUP OF LOUISIANA  
P.O. BOX 84030  
BATON ROUGE, LA 70884-4030

|||||

DENNIS DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS LA 707393530

|||||

☐ Please check box if above address is incorrect. Indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	CODE	DESCRIPTION	AMOUNT
11/07/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/07/00	85651	SEDIMENT RATE ERYTHROCYTE NON AUTOMA	6.00
11/09/00	80048	BASIC METABOLIC PANEL	19.00
11/09/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/09/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
11/09/00	87040	CULTURE BACTERIAL DEFINITIVE BLOOD	13.00
11/13/00	80053	COMPREHENSIVE METABOLIC	21.00
11/13/00	85023	CBC HEMOGRAM, PLATELET COUNT AUTO &MA	14.00
11/14/00	80053	COMPREHENSIVE METABOLIC	21.00
11/14/00	83735	MAGNESIUM	12.00

Patient :: DEARIE DENNIS  
Account :: L16838070  
Site :: OUR LADY OF THE LAKE  
Ref Phys :: RICHARD TODD COOLEY

Please Pay This  
Amount: \$ \$773.00

For Billing Questions Please Call:  
(225) 769-9993

S-2-885-001130-PATH

**STATEMENT**



# OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER

\*\* REPRINT \*\* - KSA  
HOSPITAL SERVICES

P.O. Box 14790 • Baton Rouge • LA 70898-4790

Patient's Name <b>DEARIE, DENNIS M</b>	Account Number <b>016838070-1058 I</b>	Admission Date <b>02/27/01</b>	Discharge Date <b>03/01/01</b>	Billing Date <b>06/05/01</b>
-------------------------------------------	-------------------------------------------	-----------------------------------	-----------------------------------	---------------------------------

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO  
DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWELL SPRINGS LA 70739-3530

**FEDERAL I.D. 72-0423651**

Hospital Has Private Rooms Only

IMPORTANT: PLEASE DETACH AND RETURN THE TOP PORTION OF THIS  
STATEMENT WITH YOUR REMITTANCE TO ASSURE PROPER CREDIT

COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name <b>DEARIE, DENNIS M</b>	Account NBR <b>016838070-1058</b>	Bill Date <b>06/05/01</b>	Page No. <b>SMC1</b>	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER
-------------------------------------------	--------------------------------------	------------------------------	-------------------------	-----------------------------------------------------------------------------------------------------

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
----- SUMMARY OF CHARGES -----					
----- ROOM CHARGES -----					
001		PRIVATE			
		2 DAYS AT 390.00	780.00	780.00	
		TOTAL OF ROOM CHARGES	780.00	780.00	
----- ANCILLARY CHARGES -----					
025		PHARMACY	981.07	981.07	
027		CENTRAL SUPPLIES	427.40	427.40	
030		LABORATORY	409.75	409.75	
097		LA MANDATED SERVICE CHARGE	4.00	4.00	
		TOTAL OF ALL OTHER CHARGES	1,822.22	1,822.22	
		ACCOUNT ADJUSTMENTS	4.00-		4.00-
		TOTAL CHARGES AND INSURANCE	2,598.22	2,602.22	
		NOTHING DUE AT THIS TIME			4.00-



OUR LADY OF THE LAKE  
REGIONAL MEDICAL CENTER

P.O. Box 14790 • Baton Rouge • LA 70898-4790

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HOSPITAL SERVICES

Patient's Name

DEARIE, DENNIS M

Account Number

016836070-1058 I

Admission  
Date

02/27/01

Discharge  
Date

03/01/01

Billing  
Date

06/05/01

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL)

PHONE 225/765-8872

BILL TO

DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWELL SPRINGS LA 70739-3530

FEDERAL I.D. 72-0423651

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STATEMENT WITH YOUR REMITTANCE TO ASSURE PROPER CREDIT

COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

DEARIE, DENNIS M

Account NBR

016838070-1058

Bill Date

06/05/01

Page No.

1

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/27/01	36000008	PRIVATE T40701	390.00	390.00	
02/27/01	75000810	SODIUM CHLORIDE 0.9% 100ML	40.00	40.00	
		QUANTITY OF 2			
02/27/01	75126607	HYDROMORPHONE 2MG/1ML AMP	9.00	9.00	
02/27/01	75991412	HYDROMORPHONE 50MG/5ML AMPUL	153.68	153.68	
		QUANTITY OF 4			
02/27/01	40001597	SET, IV EXTENSION 7" 4438	5.30	5.30	
02/27/01	40002343	INSYTE NEEDLE 20G X 1 1/4"	3.20	3.20	
02/27/01	40003790	IV START KIT	5.05	5.05	
02/27/01	40060219	SET, PCA TUBING	33.50	33.50	
02/27/01	40060220	SET, PCA EXTENSION	6.80	6.80	
02/27/01	40061842	ADAPTER, CLAVE MALE LL	7.65	7.65	
02/27/01	52009621	IV PUMP	43.00	43.00	
02/27/01	52060221	PUMP, PCA	72.00	72.00	
02/27/01	65005456	COMPREHENSIVE METABOLIC PANE	131.00	131.00	
02/27/01	65301105	CBC WITH AUTO DIFF	48.25	48.25	
02/27/01	65308109	URINALYSIS WITHOUT SEDIMENTA	22.75	22.75	
02/28/01	36000008	PRIVATE T40701	390.00	390.00	
02/28/01	75000018	DEX 5% W 100ML	145.86	145.86	
		QUANTITY OF 6			
02/28/01	75000307	SODIUM CHLORIDE 0.9% 500ML	40.00	40.00	
		QUANTITY OF 2			
02/28/01	75108431	NAFCILLIN 2GM VIAL	287.46	287.46	
		QUANTITY OF 18			
02/28/01	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	21.58	21.58	
		QUANTITY OF 2			
02/28/01	40001688	SOD CHL .9% INJ 1000ML	2.70	2.70	
02/28/01	40019453	IV SET, SECONDARY	5.75	5.75	
02/28/01	40019459	IV SET, PRIMARY W/O FILTER	10.00	10.00	
02/28/01	52009621	IV PUMP	43.00	43.00	
02/28/01	52060221	PUMP, PCA	72.00	72.00	
02/28/01	65305500	SED RATE	23.75	23.75	

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Patient's Name: **DEARIE, DENNIS M** Account Number: **016838070-1058 I** Admission Date: **02/27/01** Discharge Date: **03/01/01** Billing Date: **06/05/01**

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO

**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWELL SPRINGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

Hospital Has Private Rooms Only

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COMPENSATION

C07

# INSURANCE BENEFITS ASSIGNED

Patient's Name: **DEARIE, DENNIS M** Account NBR: **016838070-1058** Bill Date: **06/05/01** Page No.: **2** INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/28/01	75300202	RIFAMPIN 300MG CAP	10.72	10.72	
		QUANTITY OF 2			
02/28/01	75303267	CLONAZEPAM 1MG TABLET UD	2.25	2.25	
02/28/01	75348409	LEVSI 0.125MG TAB	1.90	1.90	
		QUANTITY OF 2			
02/28/01	75399154	ACETAMINOPHEN 325MG TABLET 2	.80	.80	
		QUANTITY OF 4			
02/28/01	75780027	VENALFAXIME XR 75MG CAP UD	8.68	8.68	
		QUANTITY OF 2			
02/28/01	75991585	LISINAPRIL 20MG TAB UD	2.30	2.30	
02/28/01	75991597	POTASSIUM CHLORIDE 20MEQ TAB	2.97	2.97	
		QUANTITY OF 3			
02/28/01	75992835	GABAPENTIN 300MG CAPSULE UD	21.92	21.92	
		QUANTITY OF 8			
02/28/01	75999570	XYCODONE SA 40MG TAB	67.20	67.20	
		QUANTITY OF 8			
03/01/01	75000018	DEX 5% W 100ML	48.62	48.62	
		QUANTITY OF 2			
03/01/01	75108431	NAFCILLIN 2GM VIAL	31.94	31.94	
		QUANTITY OF 2			
03/01/01	75243907	DROPERIDOL 2.5MG/ML 2ML AMP	10.79	10.79	
03/01/01	40002076	ICE BAG	5.15	5.15	
03/01/01	52009621	IIV PUMP	43.00	43.00	
03/01/01	52060221	PUMP, PCA	72.00	72.00	
03/01/01	65004459	MAGNESIUM-SERUM	60.00	60.00	
03/01/01	65005450	METABOLIC PANEL	124.00	124.00	
03/01/01	75300202	RIFAMPIN 300MG CAP	5.36	5.36	
03/01/01	75348409	LEVSI 0.125MG TAB	.95	.95	
03/01/01	75399154	ACETAMINOPHEN 325MG TABLET 2	.40	.40	
		QUANTITY OF 2			
03/01/01	75780027	VENALFAXIME XR 75MG CAP UD	8.68	8.68	
		QUANTITY OF 2			
03/01/01	75991585	LISINAPRIL 20MG TAB UD	2.30	2.30	



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**REGIONAL MEDICAL CENTER**

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**PRINT \*\* - KSA**  
**HOSPITAL SERVICES**

Patient's Name: **DEARIE, DENNIS M**  
Account Number: **016838070-1058 I**  
Admission Date: **02/27/01**  
Discharge Date: **03/01/01**  
Billing Date: **06/05/01**

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE  
FOR BILLING INFORMATION CALL **BUSINESS OFFICE (EL)** PHONE **225/765-8872**

BILL TO  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWELL SPRINGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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**IMPORTANT: PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR REMITTANCE TO ASSURE PROPER CREDIT**

**COMPENSATION C07**

**INSURANCE BENEFITS ASSIGNED**

Patient's Name: **DEARIE, DENNIS M**  
Account NBR: **016838070-1058**  
Bill Date: **06/05/01**  
Page No.: **3**  
INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
03/01/01	175991597	POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 3	2.97	2.97	
03/01/01	175992835	GABAPENTIN 300MG CAPSULE UD QUANTITY OF 6	16.44	16.44	
03/01/01	175999570	OXYCODONE SA 40MG TAB QUANTITY OF 4	33.60	33.60	
03/04/01	139910911	LA MANDATED SERVICE CHG IP QUANTITY OF 2	4.00	4.00	
SUB-TOTAL OF CHARGES			2,602.22	2,602.22	
03/04/01	001141511	LA MANDATED SERV CHG WRITEOFF PAID BY LA MANDATED CHG /			4.00-
TOTAL PAYMENTS AND ADJUSTMENTS					4.00-
TOTAL CHARGES AND INSURANCE			2,598.22	2,602.22	
NOTHING DUE AT THIS TIME					4.00-

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICES AND CONTINUATION SHEETS  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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STATEMENT WITH YOUR REMITTANCE TO ASSIST IN COLLECTION

**COMPENSATION C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **SM01** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
<b>----- SUMMARY OF CHARGES -----</b>					
<b>----- ROOM CHARGES -----</b>					
001		<b>PRIVATE</b>			
		39 DAYS AT 390.00	15,210.00	15,210.00	
		<b>TOTAL OF ROOM CHARGES</b>	<b>15,210.00</b>	<b>15,210.00</b>	
<b>----- ANCILLARY CHARGES -----</b>					
024		PHARMACY-SPECIAL	240.00	240.00	
025		PHARMACY	26,681.40	26,681.40	
026		IV THERAPY/SUPPLIES	95.00	95.00	
027		CENTRAL SUPPLIES	8,407.73	8,407.73	
030		LABORATORY	6,949.75	6,949.75	
031		PATHOLOGY-LAB	76.00	76.00	
032		X-RAY SERVICES	3,122.00	3,122.00	
034		NUCLEAR MEDICINE	1,982.00	1,982.00	
035		CT SCAN	2,294.00	2,294.00	
036		O.R. SERVICES	4,872.00	4,872.00	
037		ANESTHESIA SERVICES	441.00	441.00	
038		BLOOD / PROCESSING	310.00	310.00	
042		PHYSICAL MEDICINE	913.00	913.00	
071		RECOVERY ROOM	2,659.30	2,659.30	
093		OTHER THERAPUTIC SERVICES	315.00	315.00	
097		LA MANDATED SERVICE CHARGE	78.00	78.00	
		<b>TOTAL OF ALL OTHER CHARGES</b>	<b>59,436.18</b>	<b>59,436.18</b>	



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**HOSPITAL SERVICES**

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE

**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**

**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

IF YOU ARE A MEMBER OF THE HOSPITAL'S HEALTH PLAN, PLEASE DETACH AND RETURN TO THE PLAN ADMINISTRATOR. IF YOU ARE NOT A MEMBER, PLEASE RETURN TO THE HOSPITAL.

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name	Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER	
<b>DEARIE, DENNIS M</b>	<b>016838070-2022</b>	<b>03/05/02</b>	<b>SM02</b>		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
		<b>ACCOUNT ADJUSTMENTS</b>	<b>78.00-</b>		<b>78.00-</b>
		<b>TOTAL CHARGES AND INSURANCE</b>	<b>74,568.18</b>	<b>74,646.18</b>	
		<b>NOTHING DUE AT THIS TIME</b>			<b>78.00-</b>

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND INFORMATION FOR  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

BILL TO  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

RECEIVED: PLEASE DETACH AND RETURN TO: DEPARTMENT OF  
STATEMENT WITH YOUR REMITTANCE TO ADJUST: PROCEED

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name		Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER	
<b>DEARIE, DENNIS M</b>		<b>016838070-2022</b>	<b>03/05/02</b>	<b>1</b>		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION	
01/22/02	32000002	PRIVATE 056001	390.00	390.00		
01/22/02	75124156	MEPERIDINE 50MG VIAL	10.00	10.00		
01/22/02	75993600	MIRTAZAPINE 15MG TAB	24.30	24.30		
		QUANTITY OF 3				
01/22/02	65005456	COMPREHENSIVEMETABOLIC PANE	131.00	131.00		
01/22/02	65301105	CBC WITH AUTO DIFF	48.25	48.25		
01/22/02	65305500	SED RATE	23.75	23.75		
01/22/02	65600454	CRP	47.50	47.50		
01/22/02	81700475	CT-LUMBAR SPINE W/O CONTRAST	1,058.00	1,058.00		
01/22/02	75303267	CLONAZEPAM 1MG TABLET UD	11.40	11.40		
		QUANTITY OF 2				
01/22/02	75303269	CLONAZEPAM 2MG TABLET UD	7.80	7.80		
01/22/02	75348409	LEVSIN 0.125MG TAB	1.00	1.00		
01/22/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60		
01/22/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00		
01/22/02	75991584	LISINOPRIL 10MG TABLET UD	3.60	3.60		
01/22/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB	2.10	2.10		
01/22/02	75992826	VENLAFAXINE 75MG TABLET UD	14.40	14.40		
		QUANTITY OF 3				
01/22/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90		
01/23/02	32000002	PRIVATE 056001	390.00	390.00		
01/23/02	75124156	MEPERIDINE 50MG VIAL	30.00	30.00		
		QUANTITY OF 3				
01/23/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP	8.50	8.50		
01/23/02	75780171	LOVENOX 60 MG PFS	451.80	451.80		
		QUANTITY OF 3				
01/23/02	75992487	FENTANYL 75MCG/HR PATCH 1 EA	385.20	385.20		
		QUANTITY OF 2				
01/23/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML	20.00	20.00		
		QUANTITY OF 2				
01/23/02	75993600	MIRTAZAPINE 15MG TAB	24.30	24.30		
		QUANTITY OF 3				
01/23/02	84100023	HEPARIN LOCK INSERTION	21.00	21.00		



Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND COPY TO READER

**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

IF YOU ARE A PATIENT OF OUR HOSPITAL, PLEASE DETACH AND RETURN TO US WITH YOUR STATEMENT AND YOUR OWN CLAIMS TO ADJUST YOUR INSURANCE

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022** Bill Date **03/05/02** Page No. **2** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/23/02	40001597	SET, IV EXTENSION 7" 4438	5.30	5.30	
01/23/02	40002344	INSYTENEEDLE 22G X 1" QUANTITY OF 3	10.05	10.05	
01/23/02	40003790	IV START KIT	5.05	5.05	
01/23/02	40061842	ADAPTER, CLAVE MALE LL	7.65	7.65	
01/23/02	75303267	CLONAZEPAM1MG TABLET UD QUANTITY OF 2	11.40	11.40	
01/23/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
01/23/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
01/23/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/23/02	75991584	LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
01/23/02	75991597	POTASSIUMCHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
01/23/02	75992826	VENLAFAXINE 75MG TABLET UD QUANTITY OF 3	14.40	14.40	
01/23/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90	
01/24/02	32000002	PRIVATE 056001	390.00	390.00	
01/24/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 2	17.00	17.00	
01/24/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
01/24/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 5	50.00	50.00	
01/24/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
01/24/02	84100023	HEPARIN LOCK INSERTION	21.00	21.00	
01/24/02	40001597	SET, IV EXTENSION 7" 4438	5.30	5.30	
01/24/02	40002344	INSYTENEEDLE 22G X 1" QUANTITY OF 3	3.35	3.35	
01/24/02	40003790	IV START KIT	5.05	5.05	
01/24/02	40061842	ADAPTER, CLAVE MALE LL	7.65	7.65	
01/24/02	65303901	PTT	33.00	33.00	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME AND ACCOUNT NUMBER ON ALL INVOICES AND CITY OF NEW ORLEANS  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

BILL TO  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

RECEIVED BY: PLEASE DETACH AND RETURN TO: GRANTING OFFICE  
STATEMENT WITH YOUR BILLING TO ASSIST IN YOUR CLAIM

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **3** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/24/0265305005PT			29.00	29.00	
01/24/0280002850SPINE-LUMBARSURVEY			195.00	195.00	
01/24/0263215829NM-GM-67/GALLIUM(PER MCI)			240.00	240.00	
		QUANTITY OF 5			
01/24/0265214125NM-RADIOPHARMLOC TUMOR WHOL			515.00	515.00	
01/24/0275303267CLONAZEPAM1MG TABLET UD			11.40	11.40	
		QUANTITY OF 2			
01/24/0275348409LEVSIN 0.125MG TAB			2.00	2.00	
		QUANTITY OF 2			
01/24/0275780027VENALFAXIME XR 75MG CAP UD			30.40	30.40	
		QUANTITY OF 4			
01/24/0275780490TRILEPTAL 300MG TABLET UD			6.60	6.60	
01/24/0275980893PROMETHAZINE 25MG TAB UD			1.00	1.00	
01/24/0275980930TEMAZEPAM 30MG CAP UD			5.00	5.00	
01/24/0275991584LISINOPRIL 10MG TABLET UD			3.60	3.60	
01/24/0275991597POTASSIUMCHLORIDE 20MEQ TAB			4.20	4.20	
		QUANTITY OF 2			
01/24/0275999574TIZANIDINE 4MG TAB			3.90	3.90	
01/25/0232000002PRIVATE	056001		390.00	390.00	
01/25/0281902015MRI-PARAMAGNETICCONTR 20 ML			256.00	256.00	
01/25/0275203745LORAZEPAM 2MG SYR			51.90	51.90	
01/25/0275269753PROMETHAZINE 25MG/ML 1ML AMP			25.50	25.50	
		QUANTITY OF 3			
01/25/0275780169LOVENOX 80 MG PFS			301.40	301.40	
		QUANTITY OF 2			
01/25/0275993422HYDROMORPHONE 1MG AMPUL 1 ML			80.00	80.00	
		QUANTITY OF 8			
01/25/0275993600MIRTAZAPINE 15MG TAB			24.30	24.30	
		QUANTITY OF 3			
01/25/0240000127SPONGE, GAUZE 4X4 10/PK 16PL			2.00	2.00	
01/25/0240001264GLOVE, TRIFLEX WHITE 7.5			1.65	1.65	
01/25/0240002609BLADE, SURGICAL 15			1.00	1.00	
01/25/0240018030SOLUTION, BETADINE 4 OZ			2.55	2.55	



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**HOSPITAL SERVICES**

Patient's Name

Account Number

Admission  
Date

Discharge  
Date

Billing  
Date

DEARIE, DENNIS M

016838070-2022 I 01/22/02 03/02/02 03/05/02

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND CERTIFICATION

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO

DENNIS M DEARIE  
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GREENWEL SPGS

LA 70739-3530

**FEDERAL I.D. 72-0423651**

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STATEMENT WITH YOUR NEW FIDELITY TO ADAPT - PRODUCE

COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

Account NBR

Bill Date

Page No.

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

DEARIE, DENNIS M

016838070-2022 03/05/02 4

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/25/0240052444		BUNNY SET-LACERATION	43.50	43.50	
01/25/0265004459		MAGNESIUM-SERUM	60.00	60.00	
01/25/0265005450		METABOLIC PANEL	124.00	124.00	
01/25/0265301105		CBC WITH AUTO DIFF	48.25	48.25	
01/25/0281901022		MRI-LUMBAR SPINE W/VO CONTRA	1,877.00	1,877.00	
01/25/0265213829		NM-GALLIUM SCAN LIMITED	407.00	407.00	
01/25/0275303267		CLONAZEPAM 1MG TABLET UD	11.40	11.40	
		QUANTITY OF 2			
01/25/0275348409		LEVSIN 0.125MG TAB	3.00	3.00	
		QUANTITY OF 3			
01/25/0275780027		VENALFAXIME XR 75MG CAP UD	30.40	30.40	
		QUANTITY OF 4			
01/25/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60	
01/25/0275980319		WARFARIN SODIUM 5MG TAB UD	2.40	2.40	
01/25/0275980893		PROMETHAZINE 25MG TAB UD	1.00	1.00	
01/25/0275980930		TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/25/0275981076		ALPRAZOLAM 1MG TAB UD	7.60	7.60	
		QUANTITY OF 2			
01/25/0275991584		LISINOPRIL 10MG TABLET UD	7.20	7.20	
		QUANTITY OF 2			
01/25/0275991597		POTASSIUM CHLORIDE 20MEQ TAB	4.20	4.20	
		QUANTITY OF 2			
01/25/0275999574		TIZANIDINE 4MG TAB	3.90	3.90	
01/26/0232000002	056001	PRIVATE	390.00	390.00	
01/26/0275269753		PROMETHAZINE 25MG/ML 1ML AMP	25.50	25.50	
		QUANTITY OF 3			
01/26/0275780169		LOVENOX 80 MG PFS	301.40	301.40	
		QUANTITY OF 2			
01/26/0275992487		FENTANYL 75MCG/HR PATCH 1 EA	385.20	385.20	
		QUANTITY OF 2			
01/26/0275993422		HYDROMORPHONE 1MG AMPUL 1 ML	60.00	60.00	
		QUANTITY OF 6			

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INSURANCE HAS BEEN FILED

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICING AND CORRESPONDENCE  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

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PLEASE DETACH AND RETURN TO HOSPITAL WITH YOUR NEXT BILL TO ASSIST IN REBATE PROCESS

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/26/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
01/26/02	65005456	COMPREHENSIVE METABOLIC PANE	131.00	131.00	
01/26/02	65107140	CULTURE - CATHETER TIP	51.25	51.25	
01/26/02	65301105	CBC WITH AUTO DIFF	48.25	48.25	
01/26/02	65305005	PT	29.00	29.00	
01/26/02	65305500	SED RATE	23.75	23.75	
01/26/02	75303267	CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
01/26/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
01/26/02	75780027	VENALFAXIME XR 75MG CAP UD QUANTITY OF 4	30.40	30.40	
01/26/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
01/26/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/26/02	75991584	LISINOPRIL 10MG TABLET UD	3.60	3.60	
01/26/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
01/26/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90	
01/27/02	232000002	PRIVATE 056001	390.00	390.00	
01/27/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 4	34.00	34.00	
01/27/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
01/27/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 6	60.00	60.00	
01/27/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
01/27/02	240001597	SET, IV EXTENSION 7" 4438	5.30	5.30	
01/27/02	240002344	INSYTE NEEDLE 22G X 1" QUANTITY OF 2	6.70	6.70	
01/27/02	240003790	IV START KIT	5.05	5.05	
01/27/02	240061842	ADAPTER, CLAVE MALE LL	7.65	7.65	

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND UTILIZATION REQUESTS  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**  
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DEPARTMENT: PLEASE DETACH AND RETURN TO DEPARTMENT OFFICE  
STATEMENT WITH YOUR CLAIMS CHECK TO ASSIST WITH BILLING

**COMPENSATION C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **6**

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/27/0265300313		BLEEDING TIME-SIMPLATE	50.75	50.75	
01/27/0265303901		PTT	33.00	33.00	
01/27/0265305005		PT	29.00	29.00	
01/27/0275303267		CLONAZEPAM1MG TABLET UD	11.40	11.40	
		QUANTITY OF 2			
01/27/0275348409		LEVSIN 0.125MG TAB	2.00	2.00	
		QUANTITY OF 2			
01/27/0275780027		VENALFAXIME XR 75MG CAP UD	30.40	30.40	
		QUANTITY OF 4			
01/27/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60	
01/27/0275980930		TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/27/0275991584		LISINOPRIL 10MG TABLET UD	7.20	7.20	
		QUANTITY OF 2			
01/27/0275991597		POTASSIUM CHLORIDE 20MEQ TAB	4.20	4.20	
		QUANTITY OF 2			
01/27/0275999574		TIZANIDINE 4MG TAB	3.90	3.90	
01/28/0232000002	056001	PRIVATE	390.00	390.00	
01/28/0275000034		DEX 5% W 250ML	35.00	35.00	
01/28/0275126607		HYDROMORPHONE 2MG/1ML AMP	10.00	10.00	
01/28/0275126656		HYDROMORPHONE 4MG/1ML AMP	10.60	10.60	
01/28/0275186817		FENTANYL 0.05MG/ML 2ML AMP	53.60	53.60	
		QUANTITY OF 4			
01/28/0275209882		BUPIVACAINE 0.25% W/EPI 10ML	17.70	17.70	
01/28/0275269753		PROMETHAZINE 25MG/ML 1ML AMP	8.50	8.50	
01/28/0275780169		LOVENOX 80 MG PFS	150.70	150.70	
01/28/0275780603		ONDANSETRON 1MG/0.5ML INJ.	113.60	113.60	
		QUANTITY OF 4			
01/28/0275991388		VANCOMYCIN 500MG VIAL	94.80	94.80	
		QUANTITY OF 4			
01/28/0275992343		KETOROLAC 15MG/1ML SYRINGE	59.00	59.00	
		QUANTITY OF 2			
01/28/0275992512		MIDAZOLAM 1MG/ML 2ML MDV	10.00	10.00	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICES AND PAYMENT RECEIPTS  
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STATEMENT WITH YOUR REMITTANCE TO ASSIST IN YOUR BILLING

**COMPENSATION C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **7**

**INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/28/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML	30.00	30.00	
		QUANTITY OF 3			
01/28/02	75993600	MIRTAZAPINE 15MG TAB	24.30	24.30	
		QUANTITY OF 3			
01/28/02	40000012	BANDAGE, BAND-AID X-LARGE	2.55	2.55	
		QUANTITY OF 3			
01/28/02	40000104	STERISTrip, 0.5"X4"	4.10	4.10	
01/28/02	40000144	SPONGE, GAUZE RAYTEC 4X4	2.60	2.60	
01/28/02	40000163	MICROFOAM TAPE 3" PER ROLL	15.50	15.50	
01/28/02	40000303	POSITIONER, DONUT AID	3.55	3.55	
01/28/02	40000342	POSITIONER, PROTECTOR ELBOW	8.45	8.45	
01/28/02	40000609	TUBE, SUCTION 20 FT STERILE	5.90	5.90	
01/28/02	40001262	GLOVE, TRIFLEX WHITE 6.5	1.65	1.65	
01/28/02	40001264	GLOVE, TRIFLEX WHITE 7.5	1.65	1.65	
01/28/02	40001481	DRAPE, TABLE 44X76	6.65	6.65	
01/28/02	40001516	DRAPE, STERIDRAPE 18X24	75.60	75.60	
		QUANTITY OF 8			
01/28/02	40001543	GOWN, SCRUB LARGE PAPER	21.00	21.00	
		QUANTITY OF 2			
01/28/02	40001668	LACTATED RINGERS INJ USP 100	3.35	3.35	
01/28/02	40002354	NEEDLE, OR/ER 18GA X 1.5	3.40	3.40	
		QUANTITY OF 4			
01/28/02	40002394	SYRINGE, LUERLOCK CONTROL 12C	11.20	11.20	
		QUANTITY OF 14			
01/28/02	40003742	BENZOIN, TINCTURE AMPULE 3M	2.85	2.85	
01/28/02	40006457	SOLUTION, DURAPREP	21.00	21.00	
01/28/02	40016554	GLOVE, BIOGEL WHITE 7.5	22.05	22.05	
		QUANTITY OF 3			
01/28/02	40019456	IV SET, BLOOD PUMP	26.00	26.00	
01/28/02	40058247	TOWEL, BLUE O.R. STERILE 12/	31.75	31.75	
01/28/02	40059254	DRAPE, LAP VHA+	23.25	23.25	
01/28/02	40063187	PACK, OEC 5600 C-ARM DRAPE	37.00	37.00	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME AND ACCOUNT NUMBER ON ALL INVOICES AND CRYSTAL REPORTS  
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BILL TO  
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IMPORTANT: PLEASE DETACH AND MAIL TO: HOSPITAL BILLING  
STATEMENT WITH YOUR REMITTANCE TO ASSIST IN COLLECTION

**COMPENSATION C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **8**

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/28/02	50000300	GEN. IND. PER MIN. (1ST 30) QUANTITY OF 30	144.00	144.00	
01/28/02	50000745	SENSOR, SKIN TEMP	14.00	14.00	
01/28/02	50000782	ANES. MONITORING CHARGE	251.00	251.00	
01/28/02	50001353	TUBE, ENDO 2.0-9.5 FR	22.50	22.50	
01/28/02	50001452	TIP, YANKAUER SUCTION	1.60	1.60	
01/28/02	50002252	VENTILATOR	12.50	12.50	
01/28/02	50002372	NEEDLE, SPINAL 18-19GA/3.5	3.80	3.80	
01/28/02	50002374	NEEDLE, SPINAL 20-25GA 3.5" QUANTITY OF 3	14.10	14.10	
01/28/02	50016841	SENSOR GUARD BANDAGE, ADULT	5.30	5.30	
01/28/02	50030829	FILTER, HME 1000	3.65	3.65	
01/28/02	65101305	GRAM STAIN QUANTITY OF 2	77.00	77.00	
01/28/02	65102501	VIRUS CULTURE	76.00	76.00	
01/28/02	65106090	AFB SMEAR	39.50	39.50	
01/28/02	65106095	KOH PREP WET MOUNT	29.00	29.00	
01/28/02	65106171	CULTURE-EXUD/WOUND/ABSCCESS	116.00	116.00	
01/28/02	65107104	CULTURE - ANAEROBIC QUANTITY OF 2	146.00	146.00	
01/28/02	65107203	FUNGUS CULTURE	87.00	87.00	
01/28/02	65107658	CULTURE	116.00	116.00	
01/28/02	65107898	CULTURE, AFB	87.00	87.00	
01/28/02	65117658	GRIND TISSUE	26.00	26.00	
01/28/02	65117898	CONCENTRATION AFB	27.00	27.00	
01/28/02	65120337	BACTERIAL ID - SINGLE	19.25	19.25	
01/28/02	65126177	SUSCEPTIBILITY- MIC	23.75	23.75	
01/28/02	65305005	PT	29.00	29.00	
01/28/02	80002850	SPINE-LUMBAR SURVEY	195.00	195.00	
01/28/02	80010122	FLUORO PROC UP TO 1 HR	143.00	143.00	
01/28/02	70000012	SURGERY MINUTES QUANTITY OF 67	1,457.25	1,457.25	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

FOR BILLING INFORMATION CALL **BUSINESS OFFICE (EL)** PHONE **225/765-8872**

BILL TO  
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**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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## INSURANCE BENEFITS ASSIGNED

Patient's Name		Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER	
<b>DEARIE, DENNIS M</b>		<b>016838070-2022</b>	<b>03/05/02</b>	<b>9</b>		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION	
01/28/0250000305		GEN. ANESTH. EA SUCCEEDING M	27.00	27.00		
		QUANTITY OF 27				
01/28/0250000735		CATH, IV CATHLON 14-24 GA	1.95	1.95		
01/28/0250001759		KIT, LTA ANESTH	13.50	13.50		
01/28/0240001546		GOWN, SCRUB X-LARGE PAPER	40.50	40.50		
		QUANTITY OF 3				
01/28/0240006437		PEN, MARKING REGULAR	4.05	4.05		
01/28/0240017251		GLOVE, SURG BIOGEL 8	14.80	14.80		
		QUANTITY OF 2				
01/28/0240019500		GLOVE, BIOGEL WHITE 6	7.40	7.40		
01/28/0270001056		ORTHO SUPPLIES	3,900.00	3,900.00		
01/28/0283330021		RECOVERY ROOM MINUTES-2	876.80	876.80		
		QUANTITY OF 137				
01/28/0275303267		CLONAZEPAM 1MG TABLET UD	11.40	11.40		
		QUANTITY OF 2				
01/28/0275348409		LEVSIN 0.125MG TAB	2.00	2.00		
		QUANTITY OF 2				
01/28/0275780027		VENALFAXIME XR 75MG CAP UD	30.40	30.40		
		QUANTITY OF 4				
01/28/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60		
01/28/0275980893		PROMETHAZINE 25MG TAB UD	1.00	1.00		
01/28/0275980930		TEMASEPAM 30MG CAP UD	5.00	5.00		
01/28/0275991584		LISINOPRIL 10MG TABLET UD	3.60	3.60		
01/28/0275991597		POTASSIUM CHLORIDE 20MEQ TAB	4.20	4.20		
		QUANTITY OF 2				
01/28/0275999574		TIZANIDINE 4MG TAB	3.90	3.90		
01/29/0232000002		PRIVATE	390.00	390.00		
01/29/0275205450		SUCCINYL CHOLINE 20MG/10ML V	18.80	18.80		
01/29/0275269753		PROMETHAZINE 25MG/ML 1ML AMP	8.50	8.50		
01/29/0275780169		LOVENOX 80 MG PFS	301.40	301.40		
		QUANTITY OF 2				
01/29/0275992487		FENTANYL 75MCG/HR PATCH 1 EA	385.20	385.20		
		QUANTITY OF 2				



Patient's Name

Account Number

Admission  
Date

Discharge  
Date

Billing  
Date

DEARIE, DENNIS M

016838070-2022 I 01/22/02 03/02/02 03/05/02

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND PAYMENT RECEIPTS

**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

BILL TO

DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS LA 70739-3530

**FEDERAL I.D. 72-0423651**

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THIS STATEMENT IS A SUMMARY OF THE INFORMATION RECEIVED FROM YOUR INSURANCE CARRIER. IT IS NOT A CONTRACT. PLEASE DETACH AND RETURN TO THE CARRIER FOR CORRECTION.

COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

Account NBR

Bill Date

Page No.

DEARIE, DENNIS M

016838070-2022 03/05/02 10

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/29/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 8	80.00	80.00	
01/29/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
01/29/02	65305005	PT	29.00	29.00	
01/29/02	65305500	SED RATE	23.75	23.75	
01/29/02	65600454	CRP	47.50	47.50	
01/29/02	75303267	CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
01/29/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
01/29/02	75780027	VENALFAXIME XR 75MG CAP UD QUANTITY OF 4	30.40	30.40	
01/29/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
01/29/02	75980319	WARFARIN SODIUM 5MG TAB UD	2.40	2.40	
01/29/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/29/02	75991584	LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
01/29/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
01/29/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90	
01/30/02	232000002	PRIVATE 056001	390.00	390.00	
01/30/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 2	17.00	17.00	
01/30/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
01/30/02	75898205	SODIUM CHLORIDE .9% VIAL 2ML	8.50	8.50	
01/30/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 6	60.00	60.00	
01/30/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
01/30/02	65305005	PT	29.00	29.00	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND INFORMATION BEING  
FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO  
DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS LA 70739-3530

**FEDERAL I.D. 72-0423651**

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COMPENSATION

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## INSURANCE BENEFITS ASSIGNED

Patient's Name		Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER	
DEARIE, DENNIS M		016838070-2022	03/05/02	11		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION	
01/30/02	75303267	CLONAZEPAM 1MG TABLET UD	11.40	11.40		
		QUANTITY OF 2				
01/30/02	75348409	LEVSIN 0.125MG TAB	2.00	2.00		
		QUANTITY OF 2				
01/30/02	75780027	VENALFAXIME XR 75MG CAP UD	30.40	30.40		
		QUANTITY OF 4				
01/30/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60		
01/30/02	75980319	WARFARIN SODIUM 5MG TAB UD	2.40	2.40		
01/30/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00		
01/30/02	75991584	LISINOPRIL 10MG TABLET UD	7.20	7.20		
		QUANTITY OF 2				
01/30/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB	4.20	4.20		
		QUANTITY OF 2				
01/30/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90		
01/31/02	232000002	PRIVATE 056001	390.00	390.00		
01/31/02	75126656	HYDROMORPHONE 4MG/1ML AMP	10.60	10.60		
01/31/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP	8.50	8.50		
01/31/02	75780169	LOVENOX 80 MG PFS	301.40	301.40		
		QUANTITY OF 2				
01/31/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML	80.00	80.00		
		QUANTITY OF 8				
01/31/02	75993600	MIRTAZAPINE 15MG TAB	24.30	24.30		
		QUANTITY OF 3				
01/31/02	240001680	SOD CHL .9% DUAL SPOUT 500ML	2.35	2.35		
01/31/02	240019456	IV SET, BLOOD PUMP	26.00	26.00		
01/31/02	265305005	PT	29.00	29.00		
01/31/02	75303267	CLONAZEPAM 1MG TABLET UD	11.40	11.40		
		QUANTITY OF 2				
01/31/02	75348409	LEVSIN 0.125MG TAB	2.00	2.00		
		QUANTITY OF 2				
01/31/02	75780027	VENALFAXIME XR 75MG CAP UD	30.40	30.40		
		QUANTITY OF 4				
01/31/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60		

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICES AND PAYMENT REQUESTS  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

BILL TO  
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**15431 RED MAPLE PL**  
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COMPENSATION

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## INSURANCE BENEFITS ASSIGNED

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
01/31/02	75980319	WARFARIN SODIUM 5MG TAB UD QUANTITY OF 2	4.80	4.80	
01/31/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
01/31/02	75991584	LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
01/31/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
01/31/02	75999574	TIZANIDINE 4MG TAB	3.90	3.90	
02/01/02	232000002	PRIVATE 056001	390.00	390.00	
02/01/02	75126607	HYDROMORPHONE 2MG/1ML AMP	10.00	10.00	
02/01/02	75126656	HYDROMORPHONE 4MG/1ML AMP QUANTITY OF 3	31.80	31.80	
02/01/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 2	17.00	17.00	
02/01/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
02/01/02	75992487	FENTANYL 75MCG/HR PATCH 1 EA QUANTITY OF 2	385.20	385.20	
02/01/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 4	40.00	40.00	
02/01/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
02/01/02	65005456	COMPREHENSIVE METABOLIC PANE	131.00	131.00	
02/01/02	65301105	CBC WITH AUTO DIFF	48.25	48.25	
02/01/02	65305005	PT	29.00	29.00	
02/01/02	65305500	SED RATE	23.75	23.75	
02/01/02	65600454	CRP	47.50	47.50	
02/01/02	75303267	CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
02/01/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
02/01/02	75780027	VENALFAXIME XR 75MG CAP UD QUANTITY OF 8	60.80	60.80	

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE IN CAPITAL LETTERS AND ACCOUNT NUMBER ON ALL INVOICES AND CORRESPONDENCE  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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STATEMENT WITH YOUR BILLING SERVICE TO ASSIST IN YOUR BILLING.

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **13** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/01/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/01/02	75980314	WARFARIN SOD 10MG TAB UD	3.70	3.70	
02/01/02	75980732	BACLOFEN 10MG TAB UD	7.80	7.80	
		QUANTITY OF 3			
02/01/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
02/01/02	75991584	LISINOPRIL 10MG TABLET UD	10.80	10.80	
		QUANTITY OF 3			
02/01/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB	6.30	6.30	
		QUANTITY OF 3			
02/01/02	75999574	TIZANIDINE 4MG TAB	7.80	7.80	
		QUANTITY OF 2			
02/02/02	232000002	PRIVATE 056001	390.00	390.00	
02/02/02	75126656	HYDROMORPHONE 4MG/1ML AMP	31.80	31.80	
		QUANTITY OF 3			
02/02/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP	17.00	17.00	
		QUANTITY OF 2			
02/02/02	75780169	LOVENOX 80 MG PFS	301.40	301.40	
		QUANTITY OF 2			
02/02/02	75993600	MIRTAZAPINE 15MG TAB	24.30	24.30	
		QUANTITY OF 3			
02/02/02	65305005	PT	29.00	29.00	
02/02/02	75303267	CLONAZEPAM 1MG TABLET UD	11.40	11.40	
		QUANTITY OF 2			
02/02/02	75348409	LEVSIN 0.125MG TAB	2.00	2.00	
		QUANTITY OF 2			
02/02/02	75780027	VENALFAXIME XR 75MG CAP UD	30.40	30.40	
		QUANTITY OF 4			
02/02/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/02/02	75980732	BACLOFEN 10MG TAB UD	7.80	7.80	
		QUANTITY OF 3			
02/02/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
02/02/02	75991584	LISINOPRIL 10MG TABLET UD	7.20	7.20	
		QUANTITY OF 2			

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICES AND COPY REFERENCE  
**FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872**

**BILL TO**  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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IDENTIFY WITH PLEASE DETACHMENT OF BILLING INFORMATION  
STATEMENT WITH YOUR NEW NUMBER TO ASSIST IN TRACKING BILLING

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **14** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/02/02	75991597	POTASSIUMCHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
02/02/02	75999574	TIZANIDINE 4MG TAB QUANTITY OF 3	11.70	11.70	
02/03/02	232000002	PRIVATE 056001	390.00	390.00	
02/03/02	75126656	HYDROMORPHONE 4MG/1ML AMP QUANTITY OF 8	84.80	84.80	
02/03/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 5	42.50	42.50	
02/03/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
02/03/02	75992487	FENTANYL 75MCG/HR PATCH 1 EA	192.60	192.60	
02/03/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
02/03/02	65305005	PT	29.00	29.00	
02/03/02	75303267	CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
02/03/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
02/03/02	75780027	VENALFAXIME XR 75MG CAP UD QUANTITY OF 4	30.40	30.40	
02/03/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/03/02	75980314	WARFARIN SOD 10MG TAB UD	3.70	3.70	
02/03/02	75980732	BACLOFEN 10MG TAB UD QUANTITY OF 3	7.80	7.80	
02/03/02	75991584	LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
02/03/02	75991597	POTASSIUMCHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
02/03/02	75999574	TIZANIDINE 4MG TAB QUANTITY OF 3	11.70	11.70	
02/04/02	232000002	PRIVATE 056601	390.00	390.00	

Patient's Name

Account Number

Admission  
Date

Discharge  
Date

Billing  
Date

DEARIE, DENNIS M

016838070-2022 I 01/22/02 03/02/02 03/05/02

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND CERTIFICATIONS

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO

DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS

LA 70739-3530

**FEDERAL I.D. 72-0423651**

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COMPENSATION

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## INSURANCE BENEFITS ASSIGNED

Patient's Name

Account NBR

Bill Date

Page No.

DEARIE, DENNIS M

016838070-2022 03/05/02 15

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/04/0275126656		HYDROMORPHONE 4MG/1ML AMP	53.00	53.00	
		QUANTITY OF 5			
02/04/0275269753		PROMETHAZINE 25MG/ML 1ML AMP	17.00	17.00	
		QUANTITY OF 2			
02/04/0275780169		LOVENOX 80 MG PFS	301.40	301.40	
		QUANTITY OF 2			
02/04/0275992487		FENTANYL 75MCG/HR PATCH 1 EA	192.60	192.60	
02/04/0275993600		MIRTAZAPINE 15MG TAB	24.30	24.30	
		QUANTITY OF 3			
02/04/0240001597		SET, IV EXTENSION 7" 4438	5.30	5.30	
02/04/0240002344		INSYTE NEEDLE 22G X 1"	3.35	3.35	
02/04/0240003790		IV START KIT	5.05	5.05	
02/04/0240061842		ADAPTER, CLAVE MALE LL	7.65	7.65	
02/04/0265305005		PT	29.00	29.00	
02/04/0265305500		SED RATE	23.75	23.75	
02/04/0265600454		CRP	47.50	47.50	
02/04/0275303267		CLONAZEPAM 1MG TABLET UD	17.10	17.10	
		QUANTITY OF 3			
02/04/0275348409		LEVSIN 0.125MG TAB	2.00	2.00	
		QUANTITY OF 2			
02/04/0275780027		VENALEFAXIME XR 75MG CAP UD	30.40	30.40	
		QUANTITY OF 4			
02/04/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/04/0275980314		WARFARIN SOD 10MG TAB UD	3.70	3.70	
02/04/0275980732		BACLOFEN 10MG TAB UD	10.40	10.40	
		QUANTITY OF 4			
02/04/0275991584		LISINAPRIL 10MG TABLET UD	7.20	7.20	
		QUANTITY OF 2			
02/04/0275991597		POTASSIUM CHLORIDE 20MEQ TAB	4.20	4.20	
		QUANTITY OF 2			
02/04/0275999574		TIZANIDINE 4MG TAB	11.70	11.70	
		QUANTITY OF 3			
02/05/0232000002		PRIVATE	390.00	390.00	
	056601				

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND COPY FOR REFERENCE  
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**FEDERAL I.D. 72-0423651**

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STATEMENT WITH YOUR REMITTANCE TO ASSIST IN COLLECTION

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **16** **INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER**

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/05/02	75126656	HYDROMORPHONE 4MG/1ML AMP QUANTITY OF 8	84.80	84.80	
02/05/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 2	17.00	17.00	
02/05/02	75780169	LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
02/05/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML	10.00	10.00	
02/05/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
02/05/02	65305005	PT	29.00	29.00	
02/05/02	75303267	CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
02/05/02	75348409	LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
02/05/02	75780027	VENALFAXIME XR 75MG CAP UD QUANTITY OF 4	30.40	30.40	
02/05/02	75780490	TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/05/02	75980314	WARFARIN SOD 10MG TAB UD	3.70	3.70	
02/05/02	75980732	BACLOFEN 10MG TAB UD QUANTITY OF 4	10.40	10.40	
02/05/02	75980930	TEMAZEPAM 30MG CAP UD	5.00	5.00	
02/05/02	75991584	LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
02/05/02	75991597	POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
02/05/02	75999574	TIZANIDINE 4MG TAB QUANTITY OF 3	11.70	11.70	
02/06/02	32000002	PRIVATE	390.00	390.00	
02/06/02	75126607	HYDROMORPHONE 2MG/1ML AMP QUANTITY OF 10	100.00	100.00	
02/06/02	75126656	HYDROMORPHONE 4MG/1ML AMP QUANTITY OF 3	31.80	31.80	

Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE IN CAPITAL LETTERS AND ACCOUNT INFORMATION ON ALL INVOICES AND CORRESPONDENCE  
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**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

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STATEMENT WITH YOUR REMITTANCE TO ASSIST IN RECONCILIATION

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name	Account NBR	Bill Date	Page No.	INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER	
<b>DEARIE, DENNIS M</b>	<b>016838070-2022</b>	<b>03/05/02</b>	<b>17</b>		
POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/06/0275269753		PROMETHAZINE 25MG/ML 1ML AMP QUANTITY OF 2	17.00	17.00	
02/06/0275780169		LOVENOX 80 MG PFS QUANTITY OF 2	301.40	301.40	
02/06/0275992487		FENTANYL 75MCG/HR PATCH 1 EA	192.60	192.60	
02/06/0275993422		HYDROMORPHONE 1MG AMPUL 1 ML QUANTITY OF 3	30.00	30.00	
02/06/0275993600		MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
02/06/0265305005		PT	29.00	29.00	
02/06/0265305500		SED RATE	23.75	23.75	
02/06/0265600454		CRP	47.50	47.50	
02/06/0275303267		CLONAZEPAM 1MG TABLET UD QUANTITY OF 2	11.40	11.40	
02/06/0275348409		LEVSIN 0.125MG TAB QUANTITY OF 2	2.00	2.00	
02/06/0275780027		VENALFAXIME XR 75MG CAP UD QUANTITY OF 4	30.40	30.40	
02/06/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/06/0275980314		WARFARIN SOD 10MG TAB UD	3.70	3.70	
02/06/0275980732		BACLOFEN 10MG TAB UD QUANTITY OF 6	15.60	15.60	
02/06/0275980893		PROMETHAZINE 25MG TAB UD	1.00	1.00	
02/06/0275980930		TEMASEPAM 30MG CAP UD	5.00	5.00	
02/06/0275991584		LISINOPRIL 10MG TABLET UD QUANTITY OF 2	7.20	7.20	
02/06/0275991597		POTASSIUM CHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
02/06/0275999574		TIZANIDINE 4MG TAB QUANTITY OF 3	11.70	11.70	
02/07/0232000002		PRIVATE			
02/07/0275126607	056601	HYDROMORPHONE 2MG/1ML AMP QUANTITY OF 6	390.00 60.00	390.00 60.00	



Patient's Name **DEARIE, DENNIS M** Account Number **016838070-2022 I** Admission Date **01/22/02** Discharge Date **03/02/02** Billing Date **03/05/02**

PLEASE PRINT OR TYPE NAME AND ACCOUNT NUMBER ON ALL INVOICES AND USE RESPONSE CENTER FOR BILLING INFORMATION CALL **BUSINESS OFFICE (EL)** PHONE **225/765-8872**

BILL TO  
**DENNIS M DEARIE**  
**15431 RED MAPLE PL**  
**GREENWEL SPGS LA 70739-3530**

**FEDERAL I.D. 72-0423651**

**Hospital Has Private Rooms Only**

RECEIVED: PLEASE DETACH AND RETURN TO HOSPITAL WITH YOUR BILL TO ASSIST IN PROCESSING

**COMPENSATION**

**C07**

## INSURANCE BENEFITS ASSIGNED

Patient's Name **DEARIE, DENNIS M** Account NBR **016838070-2022** Bill Date **03/05/02** Page No. **18**

INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/07/0275126656		HYDROMORPHONE 4MG/1ML AMP	31.80	31.80	
		QUANTITY OF 3			
02/07/0275269753		PROMETHAZINE 25MG/ML 1ML AMP	25.50	25.50	
		QUANTITY OF 3			
02/07/0275780169		LOVENOX 80 MG PFS	301.40	301.40	
		QUANTITY OF 2			
02/07/0275991228		HEPARIN 25000 UNIT/0.45% NAC	42.50	42.50	
02/07/0275992487		FENTANYL 75MCG/HR PATCH 1 EA	192.60	192.60	
02/07/0275993422		HYDROMORPHONE 1MG AMPUL 1 ML	30.00	30.00	
		QUANTITY OF 3			
02/07/0275993600		MIRTAZAPINE 15MG TAB	24.30	24.30	
		QUANTITY OF 3			
02/07/0240019459		IV SET, PRIMARY W/O FILTER	10.00	10.00	
02/07/0252009621		IV PUMP	43.00	43.00	
02/07/0265301105		CBC WITH AUTO DIFF	48.25	48.25	
02/07/0265303901		PTT	33.00	33.00	
02/07/0265305005		PT	58.00	58.00	
		QUANTITY OF 2			
02/07/0263215154		NM-INDIUM WBC WB	530.00	530.00	
02/07/0265215254		NM-IN-111 LABELED WBC 500UCI	687.00	687.00	
02/07/0275303267		CLONAZEPAM 1MG TABLET UD	11.40	11.40	
		QUANTITY OF 2			
02/07/0275348409		LEVSIN 0.125MG TAB	2.00	2.00	
		QUANTITY OF 2			
02/07/0275780027		VENALFAXIME XR 75MG CAP UD	30.40	30.40	
		QUANTITY OF 4			
02/07/0275780490		TRILEPTAL 300MG TABLET UD	6.60	6.60	
02/07/0275980323		WARFARIN SODIUM 7.5MG TAB UD	3.60	3.60	
02/07/0275980732		BACLOFEN 10MG TAB UD	15.60	15.60	
		QUANTITY OF 6			
02/07/0275980930		TEMAZEPAM 30MG CAP UD	5.00	5.00	
02/07/0275991584		LISINOPRIL 10MG TABLET UD	7.20	7.20	
		QUANTITY OF 2			

Patient's Name

Account Number

Admission  
Date

Discharge  
Date

Billing  
Date

DEARIE, DENNIS M

016838070-2022 I 01/22/02 03/02/02 03/05/02

PLEASE PRINT NAME, ADDRESS AND ACCOUNT NUMBER ON ALL INVOICES AND STATEMENTS

FOR BILLING INFORMATION CALL BUSINESS OFFICE (EL) PHONE 225/765-8872

BILL TO

DENNIS M DEARIE  
15431 RED MAPLE PL  
GREENWEL SPGS

LA 70739-3530

FEDERAL I.D. 72-0423651

Hospital Has Private Rooms Only

IF PATIENT IS PLEASE DETACH AND RETURN TO HOSPITAL WITH YOUR BILL TO ASSIST IN RECOVERY

COMPENSATION

C07

## INSURANCE BENEFITS ASSIGNED

Patient's Name

DEARIE, DENNIS M

Account NBR

016838070-2022

Bill Date

03/05/02

Page No.

19

INSURANCE PORTION IS COMPUTED  
ACCORDING TO THE INFORMATION  
SUPPLIED BY YOUR INSURANCE CARRIER

POSTING DATE	REF NBR	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
02/07/02	75991597	POTASSIUMCHLORIDE 20MEQ TAB QUANTITY OF 2	4.20	4.20	
02/07/02	75999574	TIZANIDINE 4MG TAB QUANTITY OF 3	11.70	11.70	
02/08/02	232000002	PRIVATE 056601	390.00	390.00	
02/08/02	75126607	HYDROMORPHONE 2MG/1ML AMP QUANTITY OF 4	40.00	40.00	
02/08/02	75126656	HYDROMORPHONE 4MG/1ML AMP QUANTITY OF 12	127.20	127.20	
02/08/02	75269753	PROMETHAZINE 25MG/ML 1ML AMP	8.50	8.50	
02/08/02	75780169	LOVENOX 80 MG PFS	150.70	150.70	
02/08/02	75991228	HEPARIN 25000 UNIT/0.45% NAC	42.50	42.50	
02/08/02	75993422	HYDROMORPHONE 1MG AMPUL 1 ML	10.00	10.00	
02/08/02	75993600	MIRTAZAPINE 15MG TAB QUANTITY OF 3	24.30	24.30	
02/08/02	84100015	IV-START/RESTART	32.00	32.00	
02/08/02	40000048	DRESSING, TEGADERM 2.38X2.75 QUANTITY OF 3	3.45	3.45	
02/08/02	40001597	SET, IV EXTENSION 7" 4438 QUANTITY OF 2	10.60	10.60	
02/08/02	40002344	INSYTE NEEDLE 22G X 1" QUANTITY OF 3	10.05	10.05	
02/08/02	40003790	IV START KIT QUANTITY OF 2	10.10	10.10	
02/08/02	40061842	ADAPTER, CLAVE MALE LL	7.65	7.65	
02/08/02	40061843	PORT, NEEDLELESS VALVE W/T-CO	9.65	9.65	
02/08/02	52009621	IV PUMP	43.00	43.00	
02/08/02	65303901	PTT QUANTITY OF 3	99.00	99.00	
02/08/02	65304800	PLATELET COUNT	36.25	36.25	
02/08/02	65305005	PT	29.00	29.00	
02/08/02	63215154	NM-INDIUM WBC WB	530.00	530.00	

**THE  
BATON  
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CLINIC  
AMC**  
Established 1946

**BATON ROUGE CLINIC, AMC**  
**P. O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

**MAIN CLINIC: (225) 769-4044**  
**BUSINESS OFFICE: (225) 246-9304**  
**FEDERAL TAX ID # 72-1111417**

ADDRESSEE:

DEARIE, DENNIS M  
15431 RED MAPLE PL  
GREENWELL SPRINGS, LA 70739-3530

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.		
<input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> VISA <input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER	AMOUNT	
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
02/04/02	922.21	1867539
PAGE: 1		SHOW AMOUNT PAID HERE \$

REMIT TO:

BATON ROUGE CLINIC, AMC  
P.O. BOX 64887  
BATON ROUGE, LA 70896-4887

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## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

IF THE BATON ROUGE CLINIC, AMC, IS DIRECTLY CONTRACTED WITH YOUR INSURANCE COMPANY, WE HAVE FILED CLAIMS TO THEM ON YOUR BEHALF. HOWEVER, PLEASE NOTE THAT REGARDLESS OF INSURANCE, YOU ARE ULTIMATELY RESPONSIBLE FOR THE ACTIVITY AND BALANCE DUE ON THIS ACCOUNT. SEE REVERSE SIDE FOR MORE INFORMATION, OR CALL THE CLINIC AT THE ABOVE PHONE NUMBER. \* INDICATES INSURANCE HAS BEEN FILED.

ACCOUNT NO. 1867539

ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
724.2	012102	110	DENNIS	3		99213	ESTAB PT O V, EXP PBLM FOC	59.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	012402	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	012502	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	012802	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	012602	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
401.9	012702	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	012902	110	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
996.62	012502	131	DENNIS	1		36535	REMOVE IMP VA PORT	370.00
			Referring Phy: AZMEH, WAREF					
			Hospital: OUR LADY OF THE LAKE					
453.8	013002	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					

\* INDICATES INSURANCE HAS BEEN FILED

2/12  
JEAN

LAST PAY DATE	CLOSING DATE
07/13/00	02/04/02

If "PAY THIS AMOUNT" shows a negative (-) balance, this indicates that your private pay portion has a credit that may or may not be due to you. Do not pay this credit amount.

**BATON ROUGE CLINIC, AMC**

ACCOUNT BALANCE >>>>	922.21
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or

148

**THE  
BATON  
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CLINIC  
AMC**  
Established 1946

**BATON ROUGE CLINIC, AMC**  
**P. O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

**MAIN CLINIC: (225) 769-4044**  
**BUSINESS OFFICE: (225) 246-9304**  
**FEDERAL TAX ID # 72-1111417**

ADDRESSEE:

DEARIE, DENNIS M  
15431 RED MAPLE PL  
GREENWELL SPRINGS, LA 70739-3530

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

<input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> VISA <input type="checkbox"/> VISA <input type="checkbox"/> AMERICAN EXPRESS	
CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT
02/04/02	922.21
ACCT. #	
1867539	
SHOW AMOUNT PAID HERE \$	

PAGE: 2

REMIT TO:

BATON ROUGE CLINIC, AMC  
P.O. BOX 64887  
BATON ROUGE, LA 70896-4887

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**STATEMENT**

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ACCOUNT NO. 1867539

ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
Hospital: OUR LADY OF THE LAKE PRIVATE PAY								
Balance Due								922.21
* INDICATES INSURANCE HAS BEEN FILED								

LAST PAY DATE	CLOSING DATE
07/13/00	02/04/02

If "PAY THIS AMOUNT" shows a negative (-) balance, this indicates that your private pay portion has a credit that may or may not be due to you. Do not pay this credit amount.

**BATON ROUGE CLINIC, AMC**

**ACCOUNT  
BALANCE >>>> 922.21**

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**THE  
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**BATON ROUGE CLINIC, AMC**  
**P. O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

MAIN CLINIC: (225) 769-4044  
BUSINESS OFFICE: (225) 246-9304  
FEDERAL TAX ID # 72-1111417

ADDRESSEE:

DEARIE, DENNIS M  
15431 RED MAPLE PL  
GREENWELL SPRINGS, LA 70739-3530

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USED FOR PAYMENT		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
<input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
03/04/02	2197.21	1867539
PAGE: 1		SHOW AMOUNT PAID HERE \$

REMIT TO:

BATON ROUGE CLINIC, AMC  
P.O. BOX 64887  
BATON ROUGE, LA 70896-4887

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ACCOUNT NO. 1867539								
ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
453.8	013102	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020102	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020202	052	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: BRANDT, HAROLD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020302	052	DENNIS	1		99232	SUBSEQ HOSP VISIT LEVEL 2	74.00
			Referring Phy: BRANDT, HAROLD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020402	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020502	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020602	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	020702	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					

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LAST PAY DATE	CLOSING DATE
07/13/00	03/04/02

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**BATON ROUGE CLINIC, AMC**

**ACCOUNT  
BALANCE >>>>** 2197.21

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**BATON ROUGE, LA 70896-4887**

**MAIN CLINIC: (225) 769-4044**  
**BUSINESS OFFICE: (225) 246-9304**  
**FEDERAL TAX ID # 72-1111417**

**ADDRESSEE:**



**DEARIE, DENNIS M**  
**15431 RED MAPLE PL**  
**GREENWELL SPRINGS, LA 70739-3530**

**IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.**

CHECK CARD USED FOR PAYMENT		
<input type="checkbox"/> MONEY CARD	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
<input type="checkbox"/> VISA	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
03/04/02	2197.21	1867539
PAGE: 2		SHOW AMOUNT PAID HERE \$

**REMIT TO:**



**BATON ROUGE CLINIC, AMC**  
**P.O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

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**STATEMENT**

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**ACCOUNT NO. 1867539**

ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
453.8	020802	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	020902	064	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: HECKER, ROGER					
453.8	021202	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	021302	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	021402	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	021502	110	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: COOLEY, RICHARD TODD					
453.8	021702	051	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Referring Phy: ALVAREZ, FRANK					
453.8	021602	051	DENNIS	1		99231	SUBSEQ HOSP VISIT LEVEL 1	49.00
			Hospital: OUR LADY OF THE LAKE					

**\* INDICATES INSURANCE HAS BEEN FILED**

LAST PAY DATE	CLOSING DATE
07/13/00	03/04/02

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**BATON ROUGE CLINIC, AMC**

**ACCOUNT BALANCE >>>> 2197.21**

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**THE  
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CLINIC  
AMC**  
Established 1946

**BATON ROUGE CLINIC, AMC**  
**P. O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

MAIN CLINIC: (225) 769-4044  
BUSINESS OFFICE: (225) 246-9304  
FEDERAL TAX ID # 72-1111417

ADDRESSEE:



DEARIE, DENNIS M  
15431 RED MAPLE PL  
GREENWELL SPRINGS, LA 70739-3530

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

<input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> VISA <input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
03/04/02	2197.21	1867539
PAGE: 3		SHOW AMOUNT PAID HERE \$

REMIT TO:



BATON ROUGE CLINIC, AMC  
P.O. BOX 64887  
BATON ROUGE, LA 70896-4887

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ACCOUNT NO. 1867539								
ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
			Referring Phy: ALVAREZ, FRANK					
			Hospital: OUR LADY OF THE LAKE					
453.8	021802	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	021902	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	022002	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
401.9	022102	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	022502	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	022202	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	022302	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
401.9	022402	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00
			Referring Phy: COOLEY, RICHARD TODD					
			Hospital: OUR LADY OF THE LAKE					
453.8	022602	110 DENNIS	1	99231		SUBSEQ HOSP VISIT LEVEL 1		49.00

\* INDICATES INSURANCE HAS BEEN FILED

LAST PAY DATE	CLOSING DATE
07/13/00	03/04/02

If "PAY THIS AMOUNT" shows a negative (-) balance, this indicates that your private pay portion has a credit that may or may not be due to you. Do not pay this credit amount.

**BATON ROUGE CLINIC, AMC**

**ACCOUNT  
BALANCE >>>> 2197.21**

VISIT OUR WEB SITE AT [www.batonrougeclinic.com](http://www.batonrougeclinic.com)

**THE  
BATON  
ROUGE  
CLINIC  
AMC**  
Established 1946

**BATON ROUGE CLINIC, AMC**  
**P. O. BOX 64887**  
**BATON ROUGE, LA 70896-4887**

MAIN CLINIC: (225) 769-4044  
BUSINESS OFFICE: (225) 246-9304  
FEDERAL TAX ID # 72-1111417

ADDRESSEE:

DEARIE, DENNIS M  
15431 RED MAPLE PL  
GREENWELL SPRINGS, LA 70739-3530

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

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<input checked="" type="checkbox"/> MASTERCARD	<input checked="" type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
<input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
03/04/02	2197.21	1867539
PAGE: 4		SHOW AMOUNT PAID HERE \$

REMIT TO:

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BATON ROUGE, LA 70896-4887

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

IF THE BATON ROUGE CLINIC, AMC, IS DIRECTLY CONTRACTED WITH YOUR INSURANCE COMPANY, WE HAVE FILED CLAIMS TO THEM ON YOUR BEHALF. HOWEVER, PLEASE NOTE THAT REGARDLESS OF INSURANCE, YOU ARE ULTIMATELY RESPONSIBLE FOR THE ACTIVITY AND BALANCE DUE ON THIS ACCOUNT. SEE REVERSE SIDE FOR MORE INFORMATION, OR CALL THE CLINIC AT THE ABOVE BUSINESS OFFICE PHONE NUMBER. \* INDICATES INSURANCE HAS BEEN FILED.

ACCOUNT NO. 1867539

ICD9	DATE	DR	PATIENT NAME	P O S	I N S	CPT4	SERVICE RENDERED	AMOUNT
<p>Referring Phy: COOLEY, RICHARD TODD Hospital: OUR LADY OF THE LAKE PRIVATE PAY</p> <p>Balance Due 2197.21</p>								
<p>* INDICATES INSURANCE HAS BEEN FILED</p>								

LAST PAY DATE	CLOSING DATE
07/13/00	03/04/02

If "PAY THIS AMOUNT" shows a negative (-) balance, this indicates that your private pay portion has a credit that may or may not be due to you. Do not pay this credit amount.

**BATON ROUGE CLINIC, AMC**

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**ACCOUNT  
BALANCE >>>> 2197.21**